Tracheostomy
Information for patients

Many patients on the Intensive Care Unit (ICU) need a ventilator (breathing machine) to help with their breathing. The ventilator has to be connected to the patient by a tube in the trachea (windpipe).

This is usually done using a plastic tube in the mouth which passes through the larynx (voice box) to reach the trachea. It is safe to leave the tube in place for several days, although most patients find the presence of a tube in the throat to be very uncomfortable, and require sedative medication to make the tube acceptable.

The prolonged presence of a tube in the throat makes it difficult to keep the mouth clean, and can also lead to physical damage to the mouth, larynx and trachea. Some of these problems can be avoided with a Tracheostomy. We are recommending a tracheostomy as we believe that you/your relative will need help from the ventilator for some time to come.

What is a Tracheostomy?
A tracheostomy is a hole in the front of the neck into the trachea (windpipe). A tracheostomy tube can then be inserted through this hole into the trachea in order to allow the patient to be connected to a ventilator and to allow access for suction.

Why do I/my relative need a tracheostomy?
There are a number of reasons why a tracheostomy may be beneficial.

• A tracheostomy tube is far more comfortable than a tube in the mouth. Most patients with a tracheostomy require little or no sedation. This means that they can be more awake, more comfortable and may allow them to breathe for themselves at an earlier stage. This can actually reduce the time attached to a ventilator.

• A tube in the mouth can cause physical damage to the structures through which it passes, including the larynx (voice box), leading to problems later on with speaking.
There are specific reasons why some patients may particularly benefit from a tracheostomy. These are usually because of the particular illness which has caused the need for ventilation. The doctors in ICU will discuss any specific reasons with you.

Is it safe? Are there any risks?
Generally speaking, a tracheostomy is safe, but, like any procedure, there are some risks and complications. A tracheostomy is only performed when the potential benefits outweigh the potential risks.

The risks of having a tracheostomy may be associated with the procedure itself, the fact that an opening is made into the trachea (windpipe) and to the presence of a tube in the trachea. Most of the complications are minor and of no great significance. However, very occasionally, a severe complication may arise which may necessitate intervention.

THE MAJOR RISKS ASSOCIATED WITH THE PROCEDURE ARE: -

- Bleeding. The front of the neck contains several blood vessels, which may bleed during the formation of a tracheostomy. These can usually be dealt with very simply but occasionally require a surgical operation in the operating theatre.

- Pneumothorax. This is when air is in the chest but outside the lung, causing the lung to collapse. It can occur because of damage to the pleura (the lining surrounding the lung) or the trachea (windpipe) itself. It usually requires a drain to be placed in the chest.

- Infection. The tracheostomy can become contaminated with bacteria, either from the patient's own skin or from the secretions coughed up by the patient. Serious infection is rare

How is a Tracheostomy done?
A tracheostomy may be performed ‘percutaneously’ or ‘surgically’. Whichever method is used, you will be given a general anaesthetic.

The percutaneous (meaning “through the skin”) techniques involve making a small cut in the skin on the front of the neck and inserting a needle through this into the trachea. A guide-wire is then passed through this needle, and the hole around it is stretched until the tracheostomy tube can be inserted into the trachea. This is normally done in the Intensive Care Unit.
The open surgical technique involves making a larger incision into the neck and cutting down into the trachea, allowing a tracheostomy tube to be inserted into the trachea. This is normally done in the Operating Theatre.

Most tracheostomies are now performed using a percutaneous technique, but the technique is not suitable for all patients. Your doctor will be happy to explain in more detail which technique is best for you (your relative).

What happens afterwards?
Most tracheostomies in ICU are temporary and removed when no longer required. This may be before or after the patient leaves ICU. The tracheostomy is usually removed sometime after the patient is off the ventilator, but is sometimes left in longer especially if the patient is sleepy, or has difficulty in getting rid of chest secretions. Sometimes a valve can be attached to the tracheostomy that allows the patient to speak. This is not possible for all patients; it depends on the condition of the individual.

After the tracheostomy tube is removed, a dressing is applied to the hole and secured with tape. The hole will usually close fairly quickly, and within a week to ten days after removal, the hole will have sealed off, leaving only a small scar.

Are there any long-term problems?
Patients who have had a tracheostomy are potentially at risk from developing scarring of the inside of the trachea (windpipe), which can lead to narrowing of the trachea. This is called tracheal stenosis and can also occur with the tracheal tube. Investigations have shown that this can occur as many as 40% of patients who have had a tracheostomy, but usually cause the patient no problem.

Very rarely, patients with tracheal stenosis develop noisy breathing as the air passes through the narrowed part of the trachea. In the event of this happening, the patient's General Practitioner is advised to refer them to an Ear, Nose and Throat surgeon for investigation and treatment.

Ref: Standards for the care of adult patients with a temporary tracheostomy: Intensive care society 2008
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