Sir,

Percutaneous dilatational tracheostomy (PCT) even though has appropriately replaced the surgical tracheostomy by far in critical care settings, yet the fact that it accompanies a myriad of both trivial and nontrivial complications cannot be denied. One such complication already mentioned in literature includes inadvertent migration of guidewire into the Murphy’s eye of endotracheal tube (ETT) during PCT.[1]

A 45-year-old male patient admitted in Neuro-Intensive Care Unit (ICU) with severe head injury and already tracheally intubated and ventilated over last 5 days was scheduled for PCT on the 6th day. The procedure was being attempted using commercially available Ciaglia Blue Rhino PCT introducers. The ETT was deflated and withdrawn by 5 cm. After careful transverse skin incision, soft tissue dissection, and placement of guidewire between the 2nd and 3rd tracheal rings through the introducer needle, the tract was dilated using a series of three dilators of increasing caliber. The tracheostomy tube (TT) with obturator was then threaded over the guidewire into the trachea. However, the TT failed to enter into the trachea and a resistance was noticed. Presumably, the resistance was due to ETT at the level of tracheal stoma, so we decided to withdraw the ETT further. However, the guidewire moved in tandem with the ETT. We realized that the guidewire had entered the Murphy’s eye. As such, we removed the guidewire. We then made a blind attempt to insert the TT through the already made tracheal opening. However, it entered into a false tract. The TT was immediately removed. Ongoing ventilation through the ETT at least ensured optimum oxygen saturation. As a rescue measure, the ETT which we had withdrawn was now again advanced beyond the tracheal stoma. The proximal part of a suction catheter (having thumb control) was cut and the remaining catheter was then negotiated through the ETT into the trachea [Figure 1a]. The ETT was now again withdrawn up to the level of glottis. The oral end of the suction catheter was taken out through the tracheal stoma with distal end in distal trachea. The TT was then railed road over the oral end of the suction catheter [Figure 1b]. After confirming its correct placement, the suction catheter was removed.

Suction catheter as a crucial rescuer in lost tracheostomy tract situation during percutaneous tracheostomy

Figure 1: (a) Suction catheter (white arrow) without proximal thumb control introduced through the cathmount (black arrow) thus allowing uninterrupted ventilation. (b) Tracheostomy tube railed road over the proximal end of the suction catheter (white arrow)
We followed this method of rescue as described by Gupta et al.,[2] however, with a slight modification. Instead of a nasogastric tube, we preferred to use the suction catheter. Moreover, ventilation in our patient was uninterrupted due to the use of flexible cathmount [Figure 1a]. The flexibility of suction catheter becomes an advantage when it comes to the process of withdrawing the oral end from the tracheal rent and subsequently guiding the TT through it. In addition, it is relatively atraumatic and commonly available in any ICU setting. Nevertheless, it should be borne in mind to always check the position of guidewire (free from Murphy’s eye) during PCT before dilating the tract and making a tracheal stoma.

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Conflicts of interest
There are no conflicts of interest.

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