



## Optimal placement of nasal RAE tube

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To the Editor:

In recent article of Kim et al. [1] assessing preoperative and intraoperative factors for shallow nasal RAE tube depth after head and neck surgery, they did not clearly describe what sizes nasal tubes were used and how initial depth of nasal tube at intubation was determined. As nasal tube depth after surgery was measured by chest radiography in patient placed in the supine and neutral head positions, intraoperative factors should not affect postoperative nasal tube depth, unless the tube was distorted in the airway. We argue that postoperative shallow nasal tube depths found in this study should be mainly attributable to inadequate insertion depths at intubation.

For Asian, mean distances from the vocal cords to the carina are 13–13.4 cm in males and 11.2–12 cm in females, respectively [2]. When the proper nasal tube depth is defined as the tube tip between 2 and 7 cm above the carina, thus, an optimal placement of nasal tube can be aided with a single guide mark placed 3 cm proximal to the cuff

and 8 cm proximal to the distal end. Unfortunately, there has been no manufacturer providing such nasal tube with this guide mark and even the guide marks on the nasal tubes made by same manufacturer vary in their position relative to the cuff and distal end of the nasal tube (Fig. 1). Thus, a simple method used for optimal placement of nasal tubes in our practice is that the tube tip is passed through the vocal cords under direct vision, stopping 3 cm after the tube cuff completely passes the vocal cords. By our experience, this



**Fig. 1** The positions of guide marks relative to the cuff and distal end vary in the nasal tubes made by same manufacturer

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method may also reduce improper placement of nasal tube caused by head movement during surgery.

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### **Compliance with ethical standards**

**Conflict of interest** All authors declare that they have no conflict of interest.

### **References**

1. Kim HY, Kim EJ, Shin CS, Kim J. Shallow nasal RAE tube depth after head and neck surgery: association with preoperative and intraoperative factors. *J Anesth.* 2019;33(1):118–24.
2. Herway ST, Benumof JL. The tracheal accordion and the position of the endotracheal tube. *Anaesth Intensive Care.* 2017;45:177–88.

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