Usefulness of Ultrasonography for Selection of Correct Size Endotracheal Tube in Paediatric Patients

Amit Agrawal¹, Swati Daftary², Roshan Verghese³, Akshata Amin⁴, Sneha Raju⁵

ABSTRACT

Introduction: Colour vision defect (CVD) is the inability to perceive colour differences under normal lighting conditions. Its prevalence thought to be around 7% for men and 0.4% for women, vary from country to country, between regions in the same country, as well as between ethnic groups. Its importance lies in the fact that it is prevents a person from doing certain jobs while creating difficulties in others. Screening for CVD during childhood and counseling to guide them towards choosing appropriate career needs to be carried out.

Material and methods: Records of pre employment screening from the period 1st January 2016 to 30th April 2020 preserved in the Department of Medical Examination-I, of Atal Bihari Vajpayee Institute of Medical Sciences and associated Dr Ram Manohar Lohia Hospital were examined for the purpose of the study. The number of candidates having CVD was tabulated. Colour vision testing had been done using Ishihara’s plates.

Results: A total of 13179 candidates were screened during the period out of which 9879 were males (75%) and 3300 females (25%). 384 males (3.89%, 95% CI: 3.51%, 4.27%) and only 6 females (0.18%, 95% CI: 0.17%, 0.19%) were found to be colour vision defective giving a overall prevalence of 2.98%. There was an increase in the prevalence of colour vision defect after age 50.

Conclusions: Prevalence of colour vision defects in males is 3.89% (95% CI 3.51, 4.27%) and that of females is 0.18% (95% CI 0.17, 0.19). Screening for CVD at an early age will be beneficial to children in helping them to choose their career in light of their deficiency.

Keywords: Colour Vision Deficiency, Protanopia, Deuteranopia, Triatanopia, Gene Therapy, Pre- Employment Screening, MeSH terms, Achromatopsia, Color Blindness, Color Vision Deficiency

INTRODUCTION

A formula to predict the correct size of the ETT to be used in the pediatric patient was first proposed by Cole in 1957¹ and this is the most commonly used formula even today. Other age based formulas, like Motoyama’s², Penlington’s³ were proposed more than half a century ago. Due to the wide variations in the size of children and the frequent inaccuracy of the calculated ETT size, other complex formulae using multiple variables such as age, height and weight were proposed, but did not gain wide use in clinical practice. Intubation of paediatric patients with an ETT that is too small may result in insufficient ventilation, poor reliability of end-tidal gas monitoring, leakage of anaesthetic gases into the operating room environment, and an enhanced risk of aspiration.⁴,⁶ In contrast, an ETT that is too large can cause upper airway damage (e.g., laryngeal edema, stridor, local ischaemia, ulceration, granulation, scar formation) and potential for subsequent subglottic stenosis.⁷,⁸ Predictive formulas for appropriate ETT size have also been based on patient’s weight and height.⁹,¹¹ However, none of these work are accurate and further they do not conform to various ethnic populations across the world. This can result in repeated laryngoscopies and reintubations to identify the appropriate sized tube.

Some recent reports suggest that the diameter of the subglottic upper airway can be determined by ultrasound in healthy young adults and paediatric patients.¹²,¹³ In addition, one 2010 report from a research group in Japan showed that ultrasound can predict optimal ETT size in paediatric patients.¹⁴ Another study published by a Korean group under Baet al.¹⁵ documented the usefulness of ultrasound for selecting a correct sized uncuffed tracheal tube for intubation of paediatric patients.

Our aim was to study the usefulness of ultrasonography in prediction of appropriate size endotracheal tube in Indian pediatric age group.

MATERIAL AND METHODS

Institutional ethical committee approval was obtained for a prospective clinical observational study. 60 paediatric patients up to the age of 12 years requiring general endotracheal anaesthesia were studied. Written informed consent was obtained from the parents (guardian) of each child.

The inclusion criteria were age upto 12 years, elective surgery requiring general endotracheal anaesthesia, and normal airway.

Exclusion criteria included known allergy to ultrasound gel, age more than 12 years, pre-existing laryngeal pathology and anticipated difficult airway.

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The investigator was trained by performing 15 laryngotracheal ultrasonographic examinations under the guidance of a senior ultrasonologist, before the beginning of the study. The same investigator took all the readings.

After confirming starvation, consent and clinical findings, patients were induced with inhalational / intravenous agents. Patients were paralyzed with a non-depolarizing muscle relaxant (atracurium 0.5 mg/kg after excluding any known allergies) and before laryngoscopy, using ultrasonography, transverse tracheal diameter at the level of cricoid (subglottis) was measured in supine position with head in slight extension with linear hockey stick probe [frequency 6-13 Hz] of portable ultrasound system. Reading was taken at the highest possible resolution and with the probe placed in midline of anterior neck. Figure 1 shows an illustration of the ultrasonographic view of the cricoid arch and the air column. From the measured reading 0.5 mm was subtracted to avoid a very snugly fitting tube. The attending anaesthesiologist was blinded to the results of the ultrasound measurement. The trachea was then intubated using direct laryngoscopy. Size of the ETT was selected as follows:

1. Uncuffed ETT, with the Cole’s formula
   \[ \text{ID (inner diameter) in mm} = 0.25 \times (\text{age in years}) + 3.5; \]
2. Cuffed ETT in children aged ≥ 5 years, with the Motoyama’s formula:
   \[ \text{ID (inner diameter) in mm} = 0.25 \times (\text{age in years}) + 3.5; \]

ETT sizing technique was used to determine the optimal sized ETT. This technique utilizes leak pressure to identify optimum sized ETT in pediatric patients. The leak pressure (pressure at which leak occurs around the tube) was measured with the help of stethoscope placed in the suprasternal notch and manometer was observed for the pressure at which leak was auscultated on ventilation. In case of cuffed endotracheal tube, leak pressure was checked before inflating the cuff. Endotracheal tube size was considered optimal when the tracheal leak was detected at an inflation pressure of 10 to 25 cm H\textsubscript{2}O. If the leak was detected at pressure > 25 cm H\textsubscript{2}O the tube was exchanged with one that was 0.5 mm smaller, but if the leak occurred at inflation pressure < 10 cm H\textsubscript{2}O the tube was exchanged with 0.5 mm larger tube.

A comparison was made between calculated external diameters of the endotracheal tub from
1. Physical indices of age based formulae,
2. Predetermined by ultrasound
3. Actual clinically used ETT for intubation during general anesthesia

Choice of ETT was determined as correct if deviations were ≤ 0.3 mm from the outer diameter of the correct ETT size as decided by ETT sizing technique.

As the consecutive outer diameters of many different types and manufacturers of ETT differ by approximately 0.7 mm, hence the error of measurement must be ≤ 0.3 mm to predict the correct tube size. For example, the outer diameter of the Ruesch Safety Clear ETT (Teleflex Medical) sizes 4.5 and 5.0 are 6.0 and 6.7 mm respectively. The dotted line represents the measured air-column width.

### Statistical Analysis

After data collection, data entry was done in Excel. Data analysis was done with the help of SPSS Softwear ver 15, SigmaPlot Ver 11 and MedCalc Ver 10. Quantitative data is presented with the help of Mean, Std Dev, Mean and Interquartile range. Correlation among the study parameters was assessed with the help of Pearsons correlation coefficient. 

**RESULTS**

The demographic data (age, sex, and weight) was comparable between the two groups.

Sixty children were recruited for the study, 29 male and 31 female. The mean age was 4.98 ± 3.34 years (range 1 day to 12 years), mean height was 99.65 ± 24.57 cm (range 45 to 142 cm) and mean body weight was 17.18 ± 9.14 kg (range 1 to 37 kg).

Out of the total 60 cases cuffed ETT was used in 23 cases and uncuffed ETT in 37 cases.

The rate of irrelevant differences between the correctly sized ETT and Ultrasound determined ETT size with a maximum allowed deviation of ≤ 0.3 mm was

1. 89.18% for uncuffed tubes,
2. 86.95% for cuffed tubes.

The rate of irrelevant differences between the correctly sized ETT and ETT size determined by Age based formulae with a maximum allowed deviation of ≤ 0.3 mm was

1. 75.67% as per Cole’s formula for uncuffed tube.
2. 34.78% as per Motoyama’s formula for cuffed tube.
3. 60% as per Age based formulae as a whole for cuffed and uncuffed tubes.

As a whole the age based formulas predicted the correct size of ETT in 36 out of 60 cases i.e. 60% as compared to 88.33% by Ultrasonography (53 out of 60).

**Correlation Analysis**

**Virtual Effect of Ultrasound on the number of reintubations required**

During this study, the primary choice of ETT [based on age based formulae] was incorrect in 24 of 60 patients and a different size ETT had to be inserted. In patients whom

<table>
<thead>
<tr>
<th>Method</th>
<th>Correct tube size</th>
<th>Overestimations</th>
<th>Underestimations</th>
<th>Positive Predictive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasonography for uncuffed tubes</td>
<td>33/37</td>
<td>2/37</td>
<td>2/37</td>
<td>89.18%</td>
</tr>
<tr>
<td>Ultrasonography for cuffed tubes</td>
<td>20/23</td>
<td>2/23</td>
<td>1/23</td>
<td>86.95%</td>
</tr>
<tr>
<td>Ultrasonography Total</td>
<td>53/60</td>
<td>4/60</td>
<td>3/60</td>
<td>88.33%</td>
</tr>
</tbody>
</table>

Table-1: Comparison of Ultrasonography guided technique with the ETT of the correct size Choice of ETT was determined as correct if deviations were ≤ 0.3 mm from the outer diameter of the correct ETT size as decided by ETT sizing technique.
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<table>
<thead>
<tr>
<th>Method</th>
<th>Correct tube size</th>
<th>Overestimations</th>
<th>Underestimations</th>
<th>Positive Predictive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cole’s formula for uncuffed ETT</td>
<td>28/37</td>
<td>4/37</td>
<td>5/37</td>
<td>75.67%</td>
</tr>
<tr>
<td>Motoyama’s formula for cuffed ETT</td>
<td>8/23</td>
<td>1/23</td>
<td>14/23</td>
<td>34.78%</td>
</tr>
<tr>
<td>Age based Formulae for cuffed / uncuffed ETT</td>
<td>36/60</td>
<td>5/60</td>
<td>19/60</td>
<td>60%</td>
</tr>
</tbody>
</table>

Table-2: Comparison of Age based formulae with the ETT of the correct size Choice of ETT was determined as adequate if deviations were ≤ 0.3 mm from the outer diameter of the correct ETT size as decided by ETT sizing technique.

<table>
<thead>
<tr>
<th>Study variables</th>
<th>Pearson Correlation (R)</th>
<th>P Value</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETT size by formula</td>
<td>0.914</td>
<td>&lt; 0.001</td>
<td>Significant</td>
</tr>
<tr>
<td>ETT size by USG</td>
<td>0.977</td>
<td>&lt; 0.001</td>
<td>Significant</td>
</tr>
<tr>
<td>ETT used (Sizing technique)</td>
<td>1</td>
<td></td>
<td></td>
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Table-3: Correlation among USG and age based formulae for determination of ETT size

<table>
<thead>
<tr>
<th>Uncuffed tubes</th>
<th>Ext diameter of ETT used(mm)</th>
<th>Pearson Correlation(R)</th>
<th>P value</th>
<th>Correlation is</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETT size by USG</td>
<td>0.965</td>
<td>&lt; 0.01</td>
<td>Significant</td>
<td></td>
</tr>
<tr>
<td>ETT size by Formula</td>
<td>0.917</td>
<td>&lt; 0.01</td>
<td>Significant</td>
<td></td>
</tr>
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</table>

Table-4: Correlation among USG and age based formulae for determination of uncuffed ETT size

<table>
<thead>
<tr>
<th>Cuffed ETT</th>
<th>Ext diameter of ETT used(mm)</th>
<th>Pearson Correlation(R)</th>
<th>P value</th>
<th>Correlation is</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETT size by USG</td>
<td>0.948</td>
<td>&lt; 0.01</td>
<td>Significant</td>
<td></td>
</tr>
<tr>
<td>ETT size by Formula</td>
<td>0.769</td>
<td>&lt; 0.01</td>
<td>Significant</td>
<td></td>
</tr>
</tbody>
</table>

Table-5: Correlation among USG and age based formulae for determination of cuffed ETT size

uncuffed tube was put and Cole’s formula was used to decide the appropriate tube size, 9 patients required reintubation while when cuffed tube was put and Motoyama’s formula was used to decide the appropriate tube size, 15 patients required reintubation. This resulted in a mean number of 1.38 intubations per child. If the attending anesthesiologists, who were blinded to the results of the ultrasound measurement, had known the size of ETT according to Ultrasound, there would have been a need for reintubation in only 7 cases with a mean number of 1.11 intubations per child (Table-3, 4, 5)

**DISCUSSION**

This study has revealed the potential utility of ultrasound to measure the transverse diameter of upper airway at subglottic region for selection of the appropriate sized ETT.

Shibasaki et al. tested the hypothesis that subglottic diameter, as determined by ultrasonography, better predicts optimal ETT size than existing methods. A total of 192 patients, aged 1 month to 6 yr, who were scheduled for surgery and undergoing general anesthesia were enrolled and divided into development and validation phases. In the development group, the optimal ETT size was selected according to standard age-based formulas for cuffed and uncuffed tubes. Tubes were replaced as necessary until a good clinical fit was obtained. Via ultrasonography, the subglottic upper airway diameter was determined before tracheal intubation. They constructed a regression equation between the subglottic upper airway diameter and the outer diameter of the ETT finally selected.
In the validation group, ETT size was selected after ultrasonography using this regression equation. The primary outcome was the fraction of initial cuffed and uncuffed tube sizes, as selected through the regression formula, that proved clinically optimal. Subglottic upper airway diameter highly correlated with outer ETT diameter deemed optimal on clinical grounds. The rate of agreement between the predicted ETT size based on ultrasonic measurement and the final ETT size selected clinically was 98% for cuffed ETTs and 96% for uncuffed ETTs. Thus this study validated the usefulness of ultrasonography in determining the ETT size as in our study.

Shibasakistandardized the location and respiratory parameters for ultrasound measurement. Conditions of known or suspected laryngeal or tracheal diseases were excluded. This criterion was considered in the study of Shibasaki and in our study.

This study does not describe the term clinical fit in detail. In our study we determined optimal size of ETT by sizing technique.

Bae et al. examined 141 children below the age of 8 years. In all patients, after anesthesia induction and muscle relaxation, the ultrasound measurement of the transverse diameter of the airway at the cricoid cartilage was done with an 8- to 13-MHz linear probe under a constant airway pressure of 10 cmH\(_2\)O. Using standardized leak test (15–30 cmH\(_2\)O), ultrasound method predicted the correct uncuffed ETT in only 60% and age-based method predicted the correct tube in 31% cases (P = 0.001).

Christoph Schramm et al. evaluated the role of ultrasound in pediatric patients to compare the correct size of an uncuffed ETT with the minimal transverse subglottic diameter (MTDSA) measured by ultrasound and with tube size predicted by different age-related formulas. A total of 50 pediatric patients ≤ 5 years were enrolled. As a standard, they defined the adequate ETT size with no audible leakage below a ventilation pressure of 15 mbar and with an audible leakage above 25 mbar. The maximum allowed difference between the prediction method result and the ETT that fit was defined as 0.3 mm. Ultrasound was performed before the intubation procedure; the intubating anesthesiologists were blinded to the results of the ultrasound measurement. Agreement between the two age-based formulas most commonly used at the department and MTDSA was defined as 0.3 mm. Ultrasound was performed before the intubation procedure; the intubating anesthesiologists were blinded to the results of the ultrasound measurement. Agreement between the two age-based formulas most commonly used at the department and MTDSA was defined as 0.3 mm. Ultrasound was performed before the intubation procedure; the intubating anesthesiologists were blinded to the results of the ultrasound measurement. Agreement between the two age-based formulas most commonly used at the department and MTDSA was defined as 0.3 mm. Ultrasound was performed before the intubation procedure; the intubating anesthesiologists were blinded to the results of the ultrasound measurement.

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O. Also the above technique but is relatively simple to learn. Unlike adults, laryngeal calcification is not encountered in children. Therefore, laryngeal calcification, one of the limitations of performing ultrasonographic measurements of the larynx, does not influence ultrasonographic findings in pediatric patients. Thus, ultrasonography may be more useful for the selection of tracheal tube size in children.

Our study did not include any patient with a laryngeal pathology. Literature indicates that pre-emptive airway sonography may help in planning the airway management in cases with anticipated difficult airway, stridor, past history of tracheostomy. During the period of our study we used USG to correctly determine double lumen ETT size for one of our pediatric patients.

**CONCLUSION**

Ultrasoundography is a very useful, safe, quick, reliable noninvasive reproducible method for estimation of the subglottic tracheal diameter for selection of appropriate sized ETT in children. Our study validates the superiority of ultrasound to predict the appropriate ETT size as compared to age-based formulae both for cuffed and uncuffed ETT in children. Children with polytrauma cases in which FAST (Focused Assessment with Sonography for Trauma) forms an integral part of initial evaluation would be also benefitted with airway sonography as they may require ET intubation. Ultrasoundography of airway can have special indications in children exposed to airway radiation.

**Limitations**

Although we found Ultrasoundography superior as compared to formula based methods in predicting the ETT size for pediatric patients it is not a foolproof method. Also it cannot become a routinely used method because of the cost involved and finally is a subjective method in which the investigator has to be first trained to a particular skill level.

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**REFERENCES**