

# The No-Bite V: The New Standard of Care When Nasotracheal Suctioning is Contraindicated

(A Case Series of Three Patients)

## Abstract

To understand The No-Bite V, one must understand some difficulties and contraindications to nasopharyngeal/nasotracheal suctioning:

- Occluded Nasal Passages/Deviated Septum<sup>1</sup>
- Nasal Trauma/ Bleeding<sup>1</sup>
- Recent Nasal Fractures/Sinus Surgery<sup>1</sup>
- Elevated Coagulation Times from Blood Thinners<sup>1</sup>
- Coagulopathy or Bleeding Disorders<sup>1</sup>
- Frequent Coiling of Suction Catheters Upon Insertion<sup>1</sup>
- Basal Skull Fracture/Transphenoidal Neurosurgery (absolute contraindications)<sup>1</sup>

**Question: When Nasotracheal Suctioning is either Difficult or Contraindicated, how would you suction your patient? Answer: The No-Bite V.**

This quick Q & A explains exactly why there is a national push for The No-Bite V. Clinicians are all too familiar with situations where a patient is in need of suctioning but the nasal passageways prove to be either difficult or even contraindicated. Never before did an alternative option exist to perform pharyngeal or tracheal suctioning while avoiding the nasal pathways. In the following report, we described three cases of successful suctioning experiences w/ The No-Bite V in patients where the nasal approach to suctioning was contraindicated and unable to be done.

## Case #1

MICU, 30 y/o male, pmHx of Hepatitis C, encephalopathy, w/ actively bleeding esophageal varicies, critical condition w/ hemoglobin=5, hematocrit=15, platelets=12, religion= Jehovah's Witness, where family was refusing blood transfusions d/t religious beliefs; severe generalized weakness, ineffective cough, thick secretions, moderate respiratory distress, in need of nasotracheal suctioning, but contraindicated, risk of nasal hemorrhage too great of a risk for nasotracheal suctioning approach, so The No-Bite V was successfully used by ICU RT & RN staff for oral tracheal suctioning for 3.5 days in conjunction with BiPAP therapy.

Conclusion: The patient avoided an almost certain intubation, and most importantly avoided nasal trauma & bleeding that may have ended his life. Patient transferred from ICU to step-down unit 2.5 days later, patient seen sitting up in chair. The

patient was followed an additional 5 days and no complications identified.

## Case #2

Step-down unit, 80 y/o female, pmHx: Liver disease, currently w/ pneumonia, right lung "white out" on chest X-ray, generalized weakness, moderate respiratory distress. Patient w/ low platelets, elevated coagulation times d/t heparin drip, & low H & H. Moderate nasal bleeding noted as well as a substantial amount of suction catheter coiling d/t awake and alert nature of patient, patient coughing when nasal suctioning performed, therefore causing coiling of suction catheter in back of throat upon insertion. NJR Medical received special permission for No-Bite V use per RT & physician staff for oral tracheal suctioning in the middle of pilot study on different floor per hospital administration. Attending physician stated, "If not suctioned with No-Bite V, patient most likely would have been intubated for bronchoscopy and then re-admitted to MICU." Patient frequently suctioned deep oral tracheal with No-Bite V for 1 day and PRN for an additional 2 more days.

Conclusion: After day 1, chest X-ray remarkably better by AM rounds and subsequently; bronchoscopy/intubation/re-admit to MICU all avoided. The patient was followed an additional 5 days and no complications were identified.

## Case #3

MICU, 78 y/o female, pmHx: CAD, DM, CA, currently w/ pneumonia, generalized weakness and respiratory failure that was recently extubated and not expectorating secretions properly. Patient developed a large amount of pharyngeal secretions d/t a weak cough and was also confused and uncooperative post extubation. Nasopharyngeal suctioning was attempted and unsuccessful due to complete blockage of the nasal passages. Oral pharyngeal suctioning was attempted, but the patient was biting on the suction catheter, therefore preventing suctioning altogether. The No-Bite V was used successfully per ICU RT and RN staff for 2.5 days.

Conclusion: After day 1 of suction assistance with The No-Bite V, secretions were less and patient was able to gain strength and expectorate more effectively, aspiration and re-intubation avoided. The patient was followed an additional 5 days and no complications were identified.

## Discussion

Nasotracheal suctioning has been proven to prevent intubation

---

This article was provided by NJR Medical.

in cases intended solely for secretion removal.<sup>2-6</sup> In our opinion, when the nasotracheal suctioning approach proves to be difficult or contraindicated, an alternative method of suctioning with The No-Bite V, can also prove to prevent intubation. And if just one intubation can be prevented, an average additional hospital stay of 7 days and cost of \$29,200 can be avoided to a hospital.<sup>7-12</sup>

## References

- 1 [www.rcjournal.com/cpgs/pdf/09.04.1080.pdf](http://www.rcjournal.com/cpgs/pdf/09.04.1080.pdf)
- 2 Burton GG, Hodgkin JE, Ward JJ, editors. *Respiratory care: a guide to clinical practice*, 4th ed. Philadelphia: JB Lippincott; 1997:600-607.
- 3 Fuchs PL. Streamlining your suctioning techniques. Part I. Nasotracheal suctioning. *Nursing* 1984;14(5):55-61.
- 4 Demers RR. Management of the airway in the perioperative period. *Respir Care* 1984;29(5):529-536; discussion, 536-539.
- 5 Vender JS, Shapiro BA. Essentials of artificial airway management in critical care. *Acute Care* 1987;13(1-2):97-124.
- 6 Garvey C. Respiratory therapy function and therapy. In: Nettina SM, editor. *The Lippincott manual of nursing practice*, 7th ed. Philadelphia: JB Lippincott; 2001:221-229.
- 7 Bouza, C., Garcia, E., Diaz, M., Segovia, E., & Rodriguez, I. (2007). Unplanned extubation in orally intubated medical patients in the ICU: a prospective cohort study. *Heart & Lung*, 36(4), 270-276.
- 8 Krivopal M., Shlobin O., & Schwartzstein R. (2003). Utility of daily routine portable chest radiographs in mechanically ventilated patients in the medical ICU. *Chest*, 123:1607-1614
- 9 De Lassence A., Alberti C., Azoulay E., et al. (2002). Impact of unplanned extubation and reintubation after weaning on nosocomial pneumonia risk in the intensive care unit. *Anesthesiology*, 97:148-156.
- 10 Epstein S, Nevins M, & Chung J. (2000). *American Journal of Respiratory and Critical Care Medicine*, 161:1912-1916.
- 11 Dasta J.F., McLaughlin T.P., Mody S.H., & Piech C.T. (2005). Daily cost of an intensive care unit day: the contribution of mechanical ventilation. *Critical Care Medicine*, Jun; 33(6):1266-1271.
- 12 Candrilli S. & Mauskopf J. (2006, May). How Much Does a Hospital Day Cost? Poster at 11th Annual International Meeting of the International Society for Pharmacoeconomics and Outcomes Research, Philadelphia, PA.