Dear tracheostomized friends, I strongly advise you to switch to a closed-loop tracheal suction system.

If you are not equipped with such a system, your cannula has to be opened to perform a tracheal suction. Beside being quite repulsive to non-professional carers, it is not optimal on a septic point of view, and less efficient than a closed-loop system.

This system allows a far deeper suction, up to bronchi, which is a real advantage. It protects carers from possible projection of bodily fluids as well. *Those suctions are painless*.

Intensive care units are equipped with those closed-loop system, mainly to limit infectious risks. Of course, at home, most germs are yours, whereas intensive care units are true jungles, but better be cautious.

This system integrates itself to the tracheostomy (without any changes to it) and, as its name suggests, it is fully closed. Its manipulation and upkeep is very simple, my 9 year old daughter does it for fun.

You will find under this article the design I use, but many laboratories suggest it. In France, it is fully reimbursed, but your specialist might tell you they don’t get the point of it because it is quite costly (the monthly fee is about 500€).

Reminder that hygiene procedures in intensive care units are among the strictest in the medical world (apart from some operating rooms, of course) and that we are fragile patients, at the pulmonary level in particular.

A question deserves to be asked: why is it not systematically used? It’s kind of like you were sold a black and white TV, except that it’s about your life.

It is true that this system is not very well-known, I even met specialized doctors who never saw them. Of course, one can’t know everything. But what really makes me mad are the ones who know about them and don’t choose them since the beginning, and worse, when some patients ask about them, say “No, it’s useless”. What if it was your mother asking? Wouldn’t you give her the best? Go ask a resuscitator if they want to go back to open loop systems, they will surely tell you “What’s wrong with you? Do you want the rate of pulmonary infections in the unit to blow up?”

But for us, it is not the same thing; we are as good as dead. For some doctors, we already had the nerve to ask for a tracheostomy, if we ask for the best, we are asking to throw money down the drain.

Since we suffer from a terminal disease, I suspect some doctors, consciously or not, do dismiss us and therefore to minimize expenses on us. Which is unacceptable and deontologically borderline.

Would you keep on watching black and white TV?

PS: those technologies are evolving quite fast, a new design which would allow better suction of bronchial secretions just came out. I'm going to try it and tell you about it. It sounds quite promising, expectoration being a real issue with our disease.

Link: Avanos medical devices

Partager l'article !

Leave a comment with your Facebook account