

Managing saliva production might be one of the most recurrent and painful inconveniences of our dear disease. Many reasons can make the natural evacuation of saliva difficult. The main one is the loss of control of the muscles responsible for swallowing.

3 solutions are possible:

- A) Trying to *regulate* it, by various means.
- B) *Evacuating* it from your mouth.
- C) *Letting it flow*.

Notice that we can combine these solutions

Point by point:

A) Regulating saliva: The most commonly used ways to curb the production of saliva are the use of hyoscine, through skin patches, and atropine, through eye drops. These two molecules are chemically close, and also share the common trait to be used for their main side effect in our case: dry mouth. The primary function of these substances is far removed from the use we make of them. These are powerful, complex molecules. They can be used against Parkinson's disease, motion sickness or against some kinds of digestive pain in palliative care. They are also used for their influence on the nervous system, in the treatment against some chemical weapons. They also have multiple other side effects, especially on the cardiovascular system. You could compare it to buying a .357 Magnum to use it as a hammer.

These side effects also have side effects themselves. Mainly the drying of all the fluids of the E.N.T. sphere. This can cause dry eyes, but the main problem to be wary of is the thickening of tracheal and pulmonary secretions, especially among tracheotomized patients. A risk of mucus plug becomes non-negligible. It will generally yields to tracheal suctioning, which is not a very pleasant process.

These substances are therefore to be used with caution and with a competent medical monitoring. My own, non-medical advice, is that considering the trainwreck of complications that they can cause, *bringing these products routinely* into our lives should not be considered. *Taking them lifelong is nonsense.*

To reduce saliva production, we can also resort to slightly more radical options, such as injecting botox into our salivary glands, but this procedure seems to hold mitigated results. These same glands can also be burned through surgery, but I have limited knowledge about

this kind of procedure, so I'll refrain from elaborating on the subject.

B) Evacuating saliva thanks to suction units and mouth probes: There are two types of probes : *flexible and rigid*. Personally, I think the rigid probes, or cannulas, are much more effective. My favorites are the blue-tinged Yankauer cannulas, because they're more flexible and therefore more comfortable. Flexible probes are used for tracheal suction of open loop systems as well. I'd like to remind that for us tracheotomized patients, pulmonary septic risks are important and that a *closed loop system* must be preferred. I also remind that a mouth suction probe must never be used for a tracheal suction. Mouth germs are different from those living in the trachea.

C) Letting saliva flow: A solution that's a little less glamorous, of course, even though suction won't make you a sex symbol either. This solution is especially recommended in the case of immobilization, and I advise using high absorbency, comfortable dressings such as Zetuvit. I used them at night, but during the day I'd prefer the Yankauer solution. *Choice is yours now!*

Folks, let's take this opportunity to focus on oral hygiene. In addition to the sacrosanct bicarbonate that should be used daily, I think it should be used with other products which hold natural antiseptic virtues. For example, colloidal silver, oral sprays based on essential oils (thyme, tea tree...) or propolis.

That's it folks, have a good day. It's okay, it could've been worse, we could've gotten sick in the 18th century ☐

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