ABSTRACTS

Editorial Comment: A fixed style of presentation for this department of ANESTHESIOLOGY has purposely not been defined. It is the wish of the Editorial Board to provide our readers with the type of abstract they desire. Correspondence is invited offering suggestions in regard to the length of abstracts, character of them, and source of them. The Board will appreciate the cooperation of the membership of the Society in submitting abstracts of outstanding articles to be considered for publication.

GILLESPIE, N. A.: *Blind Nasotracheal Intubation.* Anesth. & Analg. 29: 217–222 (July–Aug.) 1950.

Dr. Gillespie observes that blind nasotracheal intubation has never achieved great popularity in this country. He feels that the reasons for this "rhinophobia" stem from several prejudices. Armed with results of his own large experience, the writer gives battle for the technique which he advocates so strongly.

That the method is difficult or uncertain is claimed chiefly by those who have had little experience with the technique. In the author's hands the method was successful in 85% of his first 1700 nasal intubations. After another thousand intubations he was successful 95% of the time. Experience has shown that those patients in whom laryngoscopy is most difficult are those in whom blind nasal intubation is most readily accomplished. It is true that in some situations, therapeutic intubation of the moribund patient, for instance, the direct visual approach may be more certain. However, the case of patients in mechanical respirators, or patients with ankylosis of the mandible or those suffering from Ludwig's angina, direct laryngoscopy may be impossible. The anaesthetist must then rely on blind nasal intubation.

The objection of increased trauma or liability of infection of the respiratory tract is invalidated by the author's own records of complications together with those of the State of Wisconsin General Hospital. Both of these series show insignificant differences in respiratory morbidity between the nasal and oral routes. The writer feels that routine inspection of the larynx and pharynx before intubation is neither necessary nor justifiable unless disease of those structures is suspected, since the anaesthetist (perhaps not having the diagnostic and manipulative skill of a bronchologist) is more likely to traumatize tissues with the metal blade of the laryngoscope than with a soft flexible rubber tube.

There is no disagreement that larger tubes can be passed through the mouth than through the nose. However, the advantages of a large tube are of significance only when an inflatable cuff or pharyngeal pack is used. In other cases the patient breathes around the tube as well as through it. A smaller tube will pass through the nose more readily, will be less likely to cause epistaxis, and will increase the number of successful intubations.

The ability to intubate without recourse to a laryngoscope is a most valuable 'trick" for every anaesthetist. Those who master the technique will be amply rewarded for their pains.

J. H. M.