Anesthesiology
V 45, No 2, Aug 1976

Correspondence

Use of a Suction Catheter to Assist Blind Nasal Intubation

To the Editor:—Passing the endotracheal tube through the nose into the trachea can be difficult. At times the problem arises when the endotracheal tube becomes impinged near the introitus of the larynx and fails to slide into the trachea even though breath sounds are heard through the endotracheal tube. The whistling character of the breath sounds indicates a restriction at the endotracheal tip as it lies near the introitus. I have found that the obstruction often can be overcome by holding the endotracheal tube securely so it will continue to be in line with the glottic orifice while a long firm suction catheter is fed through the endotracheal tube, until the tip of the suction catheter passes into the trachea.

The downward pressure on the endotracheal tube is then relaxed and reapplied. This maneuver usually allows the endotracheal tube to pass the obstruction and go down into the trachea. The catheter has been used only when the usual maneuvers of flexing of the neck and changing the position of the head have failed.

The explanation for the cause and effect of the problem has not been visually identified. Each time visual efforts have been made to identify the area of obstruction, the anatomic position of the obstructing area has changed and the endotracheal tube has passed into the trachea. It is presumed that the tip of the endotracheal tube becomes mechanically trapped by an anatomic structure such as the vocal or ventricular fold, the tip of the epiglottis, or one of the laryngeal cartilages that has been realigned with placement of the laryngoscope. The suction catheter in the trachea acts as an introducing guide that is in place to direct the endotracheal tube past the obstructing tissues.

In 1961, Findley[1] described the use of a nasogastric tube inserted into the trachea via the nose as a guide for inserting a nasotracheal tube where all other attempts at oral and nasal intubation had failed.

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REFERENCES

1. Findley, CW Jr, Aaron CJ: A Guided nasotracheal method for insertion of an endotracheal tube. Anesth Analg 40:640–642, 1961

(Accepted for publication April 12, 1976.)

Carbon Dioxide Absorber Packaging Hazard

To the Editor:—Recently our department had two dangerous anesthetic mishaps due to our failure to remove the paper seals from the top and bottom of prepackaged Baralyme® Granules (National Cylinder Gas #500533-65, Chicago, Illinois). In both cases the obstruction in the carbon dioxide absorber was interpreted as a problem of diminished patient pulmonary compliance.

The paper seals on these canisters have printed on them, "remove label from top and bottom before use." This caveat, in a sense, acknowledges this hazardous package design. One of the following two solutions would reduce the possible misuse of these canisters: 1) The packaging could be changed to omit paper seals. 2) The paper seals should be enlarged and constructed of a bright contrasting color such that if the seals have not been removed, they will be readily seen in the assembled carbon dioxide absorber.

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(Accepted for publication April 12, 1976.)