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More on Management of the Difficult Airway

To the Editor:—I read, with interest, the article by Bedger *et al.*[1] outlining the use of a jet-stylet endotracheal catheter for the management of patients with a difficult airway. We have used a similar technique in our institution. In place of the "jet-stylet," however, we use an 18-French Salem Sump tube with the proximal end of the tube cut off. This allows us to connect our jet ventilator directly to the suction port of the Salem Sump tube. This tube has multiple side holes at the distal end, allowing for ventilation at low gas flows per orifice.

Additionally, during changing endotracheal tubes in the Intensive Care Unit, the nasogastric tube can be passed through the endotracheal tube, the endotracheal tube can be removed, and the patient ventilated prior to or during the endotracheal change process. This technique has been described as a means of changing endotracheal tubes damaged during orthognathic procedures.[2]

The nasogastric tube is inexpensive, readily available, and easy to use if a jet-stylet is unavailable.

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Foreign Body from a Tube of Anesthetic Ointment

To the Editor:—The common practice of lubricating endotracheal tubes with water-soluble ointment may pose an additional risk to our patients. Prior to insertion of an endotracheal tube, pre-lubricated with Xylocaine 5% ointment (Astra Pharmaceutical Products Inc., manufactured by MK Laboratories, Inc., lot #511004, expiration date 11/88), light was noted to be reflected off a foreign body. Closer examination revealed that the small plastic cap liner had become delaminated from its backing and was stuck to the ointment. The plastic seal is clear, and not radioopaque, so its detection to and after insertion of the endotracheal tube would be very difficult. Figure 1 shows the defect as discovered. Examination of our supplies revealed the same defect to exist in many other tubes of the same ointment.

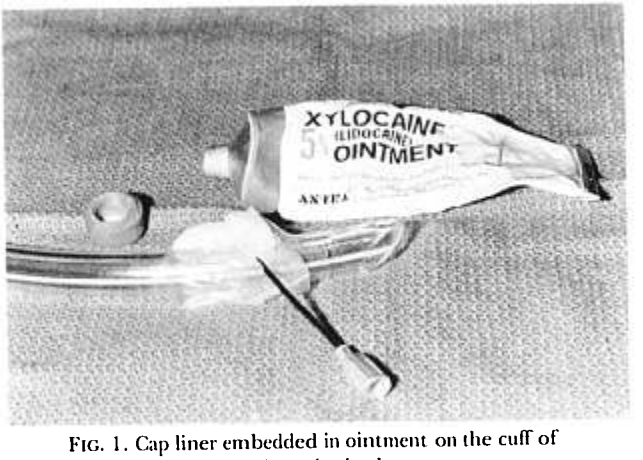

FIG. 1. Cap liner embedded in ointment on the cuff of the endotracheal tube.

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In Reply:—Astra attempts to diligently monitor the safety and effectiveness of its products and, in this effort, carefully evaluates all spontaneous reports from health professionals throughout the United States. Reports such as Mr. Jackson's enable us to become aware of problems, and allow us to take expeditious corrective action.

Review of our files indicates that a total of 12 similar complaints from seven reporting sources have been received since 1983. There have been no reports of patient injury associated with any of these reports.

Astra receives tubes and lined tube caps preassembled from a supplier. The individual cap liners are produced by a punch-out process from a large sheet of mylar liner bound to a pulp backing. We believe that rare detachment of the mylar liner from the pulp backing may be he result of occasional small areas of incomplete bonding between these two materials.

Accordingly, we have contacted the supplier of tubes and tube caps used for Xylocaine® Ointment and Xylocain® Jelly, and are seeking implementation of additional measures to assure that the pulp-plastic laminating step in preparing the cap liner is performed such that the lamination is always uniform and complete.

Other measures being investigated include the introduction of a new closure system which would not require a mylar liner bound to pulp for effective tube closure.

In addition, we have applied to the Food and Drug Administration for use of an easily visualized black rubber liner in the tube caps of Xylocain® 2% Jelly. This would allow immediate detection, by the practitioner, of improper liner detachment from the cap, should it occur.

Astra continues to actively pursue this matter in order to assure correction of the problem. We thank Mr. Jackson and Dr. Welch for notifying us of their concerns, and encourage all practitioners who encounter similar situations to do the same.

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