

CORRESPONDENCE

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In Reply:—Recommendations enthusiastically promoting the insufflation of oxygen through fiberoptic instruments during intubation are ubiquitous in the literature on this subject. Considerable effort would have to be made to locate a monograph lacking such advice. It is, therefore, all the more remarkable that we were able to do so inadvertently in the case of Ovassapian and Mesnick's 1995 article.¹ They recommend insufflation in this paper, but correctly point out that it is mentioned only in a discussion of local anesthetic delivery. We apologize for misconstruing their advice.

The writers' observation that small size fiberoptic scopes are a "poor choice" for routine adult use deserves emphasis. The larger instruments offer not only better suction but also improved optics, illumination, and handling characteristics. Further, the relatively tight fit of an 8-mm endotracheal tube on these full-sized instruments eliminates the "play" between scope and tube, which contributes to the occasional difficulty in advancing the tube over the scope into the airway. It is wise to reserve the small caliber instruments for patients who require a small endotracheal tube, such as

the patient we described,² whose laryngeal caliber was markedly reduced by soft-tissue swelling.

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Kinking of the Proximal End of a Nasal RAE Tube after Intubation via Laryngeal Mask Airway: An Alternative Stabilization Approach

To the Editor:—Tracheal insertion of an endotracheal tube (ETT) via laryngeal mask airway (LMA) to manage the difficult airway has been recently described.¹ This method requires additional custom-made tools. One drawback or disadvantage in using a 34- to 35-cm long nasal RAE (developed by the medical professionals Ring, Adair, and Elwyn) to perform tracheal intubation via LMA is kinking of the 2- to 5-cm long protruding part of the ETT at the proximal connector of the LMA as described by Roth and Benumof.² To avoid this kinking, Roth and Benumof² suggest the use of a readily available standard 15-mm internal diameter, male-to-male anesthesia circle hosing adapter to stabilize the proximal part of the ETT protruding from the LMA shaft.² Although simple and useful, this solution is not perfect. If the patient's trachea is very short, the proximal part of the 34- to 35-cm nasal RAE may be more than 5 cm outside of the LMA shaft. In these patients, the anesthesia circle hosing adapter is not long enough to stabilize the tube, and it may act as a fulcrum, possibly kinking the proximal part of the ETT. Further, when the LMA is removed, the patient's upper teeth may act as another fulcrum, risking a kink of the ETT still in place.

Additionally, the extra length of the ETT increases the danger

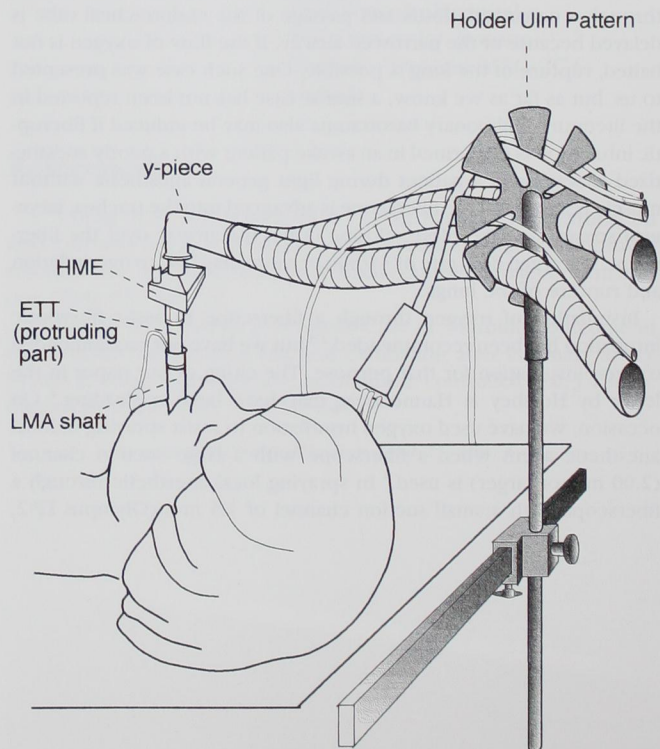


Figure 1. Holder Ulm Pattern adjusted at a mid-level according to the short length of the endotracheal tube's proximal part protruding from the laryngeal mask airway shaft.