

Atraumatic nasal intubation

Trauma associated with nasotracheal intubation is common, from minor mucosal damage with epistaxis through

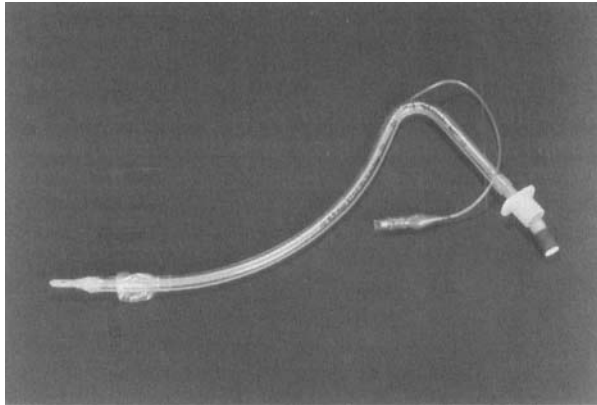


Fig. 1.

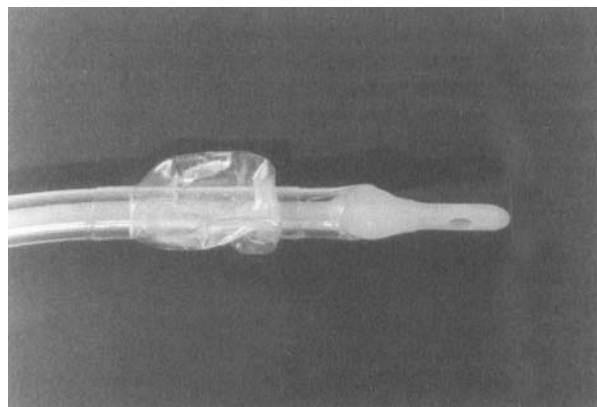


Fig. 2.

to dislodgement of polyps, adenoids or turbinates with haemorrhage and or airway obstruction or even false passages with penetration of cranial vault [1]. Previously I have used a technique involving the use of the fluted end of a red rubber catheter passed over the end of the tracheal tube [2]. This is effective but has the problem that one still has to visualise the oropharynx, pass the catheter out through the mouth then remove the catheter; the catheter has to be attached securely so that it doesn't fall off, but not sufficiently loose to be removable.

As an alternative, passage of a Foley catheter to the end of the tube then inflated with saline (the saline discourages bulging), results in a smooth tapered end (Figs 1 and 2). As well as the smooth taper it allows ample application of lubricant. This can be passed much less traumatically with lessened danger of disturbing intranasal structures or creating false passages and absolutely no risk of obstruction of the tip with debris. Once in the oral cavity it can be advanced 'blind' or under vision by laryngoscopy, the catheter being deflated and removed once passed through the cords, or it can be deflated at this stage and passed under fibre optic guidance.

I have been using this technique as a routine and found it particularly useful for fibreoptic guided nasal intubation.

Leicester Royal Infirmary,
Leicester

W. RUSSELL

References

- [1] CAMERON D, LUPTON BA. Inadvertent brain penetration during neonatal nasotracheal intubation. *Archives of Diseases in Children* 1993; **69**: 79-80.
- [2] BECKER DW JR, BASS CB, WILLIAMS VL. An aid to nasotracheal intubation in orthognathic surgery. *Cleft Palate Craniofacial Journal* 1993; **30**: 350.

Anaesthesia for cardioversion

We read with interest the recent article by Stoneham (*Anaesthesia* 1996; **51**: 565-70) on anaesthesia for cardioversion. We would like to comment on two points. The first is that the first use of diazepam in cardioversion was reported by Nutter and Massumi [1] in 1965 and not by Kernohan [2] in 1966 as cited by the author. The second involves the use of thiopentone, as there was no description of its use by Hooker *et al.* [3] in 1933; thiopentone was introduced as an intravenous anaesthetic in 1934.

Osaka Kosei-Neukin Hospital,
Osaka 553,
Japan

Y. KUBOTA
Y. TOYODA

- [3] HOOKER DR, KOUWENHOVEN WB, LANGWORTHY OR. The effect of alternating electrical currents on the heart. *American Journal of Physiology* 1933;**103**: 444-54.

A reply

Thank you for the opportunity to reply. Dr Kubota has pointed out an unintentional error in my article entitled 'Anaesthesia for cardioversion'. Thiopentone was used in the first case report of cardioversion in humans by Lown in 1962 [1] and not by Hooker in 1933. I apologise for the mistake.

University of Michigan Medical Center
Ann Arbor,
Michigan, MI 48109-0048,
USA

M. STONEHAM

References

- [1] NUTTER DO, MASSUMI RA. Diazepam in cardioversion. *New England Journal of Medicine* 1965; **273**: 650-1.
- [2] KERNOHAN RJ. Diazepam in cardioversion. *Lancet* 1966; **i**: 718-9.

References

- [1] LOWN B, AMARSINGHAM R, NEUMAN J. New method for terminating cardiac arrhythmias. *Journal of the American Medical Association* 1962; **182**: 548-55.