Current Comment and Case Reports

On March 22, 1949, he was transported by chartered plane to his home 400 miles away.

The patient is alive at present, his condition essentially unchanged neurologically. The tracheotomy is used for suction and he is being cared for by three special nurses. If he has tracheal and laryngeal damage because of the prolonged intubation it is not evident in his vegetative state.

Summary

Two cases of head injury are reported in which endotracheal tubes were in place for twelve and seventy-seven days respectively.

In Case 1, necropsy showed erosion at the point occupied by the tip of the endotracheal tube. The larynx was not examined.

Case 2 is alive at present in a vegetative state and any damage remains undetermined. It would seem, however, that any damage to the trachea has healed without serious sequelae.

Audrey Glenn Urry, M.D.,
6540 N. 14th Street,
Phoenix, Ariz.

An Improved Catheter Stop *

Generally the stilet has been used by anesthesiologists to aid in directing the insertion of endotracheal catheters. It is particularly useful in inserting cuffed tubes or in instances of distortion of the glottis. Many anesthetists use a simple wire as a stilet; however, the endotracheal tube is not held stable and there is always the danger that the wire will protrude beyond the opening of the endotracheal tube and cause damage to the cords or lacerate the soft tissues of the pharynx and larynx. To prevent this from happening it is essential that the introducer be placed so that the end is a safe distance from the distal opening of the endotracheal catheter.

It is necessary, therefore, that a stop be provided for the director so that it cannot possibly slip too far into the endotracheal tube. A stop which has been used previously has not proved entirely satisfactory because the screw tends to slip and allow rotation of the endotracheal tube so that a completely stable result is not obtained. Furthermore, no provision was made for that period during which the patient's airway is blocked by the stop immediately after the insertion of the tube into the trachea.

With the above considerations in mind, we devised an improved type of stop which has been used clinically and found to be satisfactory. Its main parts consist of:

* This apparatus can be obtained on order from Mr. Carl M. Schwartz. At present, letters of inquiry should be addressed to: D. H. Haselbuhm, M.D., Harrisburg Hospital, Harrisburg, Pa.
(1) a male adapter which fits into the connecting piece or catheter slip joint. The adapter is perforated so that the patient's airway cannot be obstructed by the catheter stop. Also, the perforations cause a characteristic hissing sound when the tube is in the trachea and the patient is breathing temporarily through the catheter stop. (2) A chuck is fused to the adapter (fig. 1).

To use the catheter stop, it is necessary to slip it along the stilet until the desired point is reached. The chuck is then tightened by simply turning it. The male adapter is fitted into the catheter slip joint and the apparatus is ready for use (fig. 2). It is often necessary to bend the stilet at the point at which the male adapter fits into the slip joint in order to assure a firm fit (fig. 3). The result is an easily directed, stable tube ready for insertion into the trachea.

The arrangement described has been found satisfactory during clinical trials. It is recommended that the endotracheal tube be introduced by using only two fingers to prevent the application of too much pressure against the cords during insertion.

D. H. HABELHUHN, M.D.,
Director of Anesthesiology,
Harrisburg Hospital,
Harrisburg, Pa.
and CARL M. SCHWARTZ,
Student in Engineering,
University of Toledo,
Toledo, Ohio