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## CORRESPONDENCE

*To the Editor:*

Occasionally the anesthesiologist is called to insert gastric tubes on the ward using laryngopharyngoscopy Often, because of anatomic variations in patients or because of irrational, uncontrollable patient behavior, this task is extremely difficult. Recently, we have had several patients who were disoriented and in whom gastric distention had developed. Because of this distention, we were reluctant to give pentothal sedation, believing that with the resulting depression the patients might suddenly regurgitate and aspirate (this has occurred in patients whose stomachs, although supposedly empty, suddenly emptied themselves of large amounts of fluid after only small amounts of pentothal had been administered).

A very helpful and entirely satisfactory method of nasal gastric intubation was devised. A firm yet flexible Magill rubber endotracheal tube of oral length is inserted transnasally to the hypopharynx. The head is then flexed sharply on the chest to direct the gastric tube into the esophagus. The Levin tube is then lubricated and threaded through the Magill tube. This sheathing action of the Magill tube prevents kinking of, or endotracheal intubation with, the gastric tube.

With this maneuver, we have found it easy to insert gastric tubes in difficult cases.

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