The Esophageal Stethoscope and Operations on the Neck

To the Editor:—In a recent article, Schwartz and Downes reported inadvertent esophageal laceration where the esophageal stethoscope was misidentified as either endotracheal tube or ventricular–jugular shunt.1 McLaughlin, in a Letter to the Editor, concluded that this complication was related to the skill of the surgeon.2 We recently had an experience similar to that of Drs. Schwartz and Downes. The patient was a newborn with a cystic hygroma necessitating emergency tracheostomy whose esophagus was incised when the esophageal stethoscope was misidentified as the endotracheal tube. This case re-emphasizes the importance of the admonition by Drs. Schwartz and Downes to communicate with the surgeon about what catheters might be palpable when neck dissection is performed in a child.

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References
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Routine Gastric Aspiration

To the Editor:—Since the advent of disposable, plastic, gastric sump tubes, orogastric aspiration of stomach contents is a readily accomplished maneuver. For several years, I have made frequent, almost routine use of this maneuver in patients undergoing general endotracheal anesthesia, except where it hinders the surgeon. In 500 to 600 such cases per year, I have had only one complication. In one patient, undefined bleeding from the distal esophagus or stomach occurred during a minor urologic procedure. The bleeding stopped spontaneously and there were no sequelae. During these several years, I have taken some amusement in showing the surgeons a suction bottle with various amounts of clear through various hues of green and brown acidic fluid while repeating the dictum I heard years back from my learned professors: “There ain’t no such thing as an empty stomach!”

I have measured by suction bottle estimate the gastric contents aspirated from my last 90 patients undergoing general endotracheal anesthesia. These were mostly adult inpatients from a 225-bed suburban community hospital undergoing elective operations, with a few emergencies and outpatients. No obstetric or cardiovascular patient was included. From 58 patients I recovered 30 to 750 ml of gastric contents by aspiration and gravity drainage in the period immediately after induction. Of the remainder, five patients had no recoverable gastric contents and 27, as much as 25 ml of gastric contents. One patient, from whom I could recover no fluid, was obese. The 750-ml volume was aspirated from the stomach of a thin, nervous woman who, three days after a hysterectomy, underwent a cytectomy and pyelography late in the day.

My conclusion is that my professors were right. We cannot predict the exceptional patient with an empty stomach. Most patients have some aspirable gastric fluid. A cuffed endotracheal tube will protect them while it is in. Routine drainage of gastric contents may provide additional safety and lessen the discomfort of emesis in the early postoperative period.

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Homogeneous Gas Mixtures in the Bain Circuit

To the Editor:—Rayburn and Graves1 state that if the minute ventilation is three times the fresh gas inflow into the Bain circuit, expired gases and fresh gas inflow will mix homogeneously. In a laboratory study of the Bain circuit (a coaxial version of the Mapleson D systems),2 we recorded the oscillations of the indi-