

## Correspondence

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### Another Technique for Insertion of Nasogastric Tubes

*To the Editor:*—Insertion of nasogastric tubes in anesthetized patients can be a frustrating experience.<sup>1</sup> In offering suggestions to simplify their insertion, Lind and Wallace omit mentioning one method that we have used with good success. A tap-water-cooled, well-lubricated nasogastric tube is passed into the posterior pharynx in the usual manner. Then the alae of the thyroid cartilage are grasped between the thumb and index fingers and lifted anteriorly. The esophagus normally is collapsed due to gravity, and this maneuver opens the esophagus. In a large proportion of patients the tube readily passes to the stomach. The thyroid cartilage on occasion is not easy to grasp, but with a little practice and skill this maneuver can be used very effectively even in small

children. Vigorous palpation of the thyroid cartilage and adjacent structures may activate the carotid sinus reflex, so heart rate and blood pressure should be followed.

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#### REFERENCE

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### Mechanical Aberrations with Pulmonary-artery Catheters

*To the Editor:*—Various complications during placement of flow-directed pulmonary-artery catheters have been reported. We recently experienced two additional problems which, to our knowledge, have not been previously described. Following uneventful placement into an internal jugular vein of what appeared to be an intact pulmonary-artery catheter, a recurring attenuation of its signal caused concern. After a prolonged search, it was discovered that the small "distal" conduit intermittently kinked at the junction of its recorder adaptor. Saline solution could be injected, but blood samples could not be withdrawn. After systematically checking every possible reason for not obtaining a satisfactory pressure tracing, we found that an adhesive tag that had been placed on the distal designated portion of the catheter for quick identification purposes was the cause. The weight of the tape alone was sufficient to kink the catheter and attenuate the tracing. As soon as the tape was removed, an appropriate pulmonary arterial pressure tracing was obtained.

A second complication resulted from a defect in the assembly of the catheter at the time of its manufacture. Fluid was found to be leaking at the junction of the catheter with its adaptor. The adaptor and catheter, which had appeared to be extruded as a single unit, were instead two separate parts fitted into one another, the joint concealed under a plastic coating (fig.

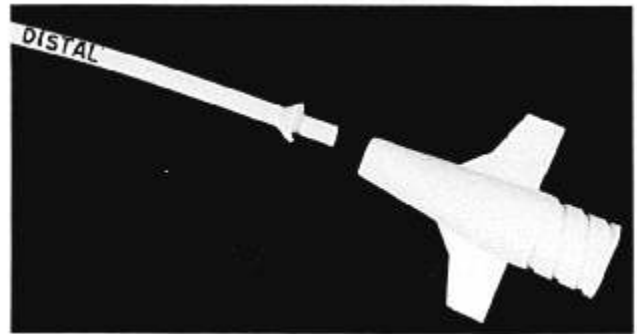


FIG. 1. Catheter and adaptor were found separated into two parts at mid-operation.

1). To avoid inserting another catheter, a Hollister medical adhesive spray patch was applied to this joint. This patch kept the two pieces together and prevented further leakage of fluid. The manufacturer was notified and the catheter was returned for inspection.

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