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A Balloon Catheter for Nasal Intubation

To the Editor:—We recently experienced a complication from nasal intubation when a small nasal polyp was dislodged into the trachea by the endotracheal tube. Because of that experience, we now insert a Foley balloon catheter to obturate the end of the endotracheal tube so that it cannot carry a foreign body into the trachea (fig. 1). Because of its diameter, flexibility, length, and balloon size, a Foley 12 F catheter is the best for nasal intubation in adult patients. The catheter should be well lubricated, suitably placed in the endotracheal tube, and inflated with air using a three-way stopcock before intubation. After intubation is completed, the catheter should be removed with the balloon deflated. We have not experienced any problems with this technique and believe that this method will reduce the incidence of complications associated with nasal intubation.

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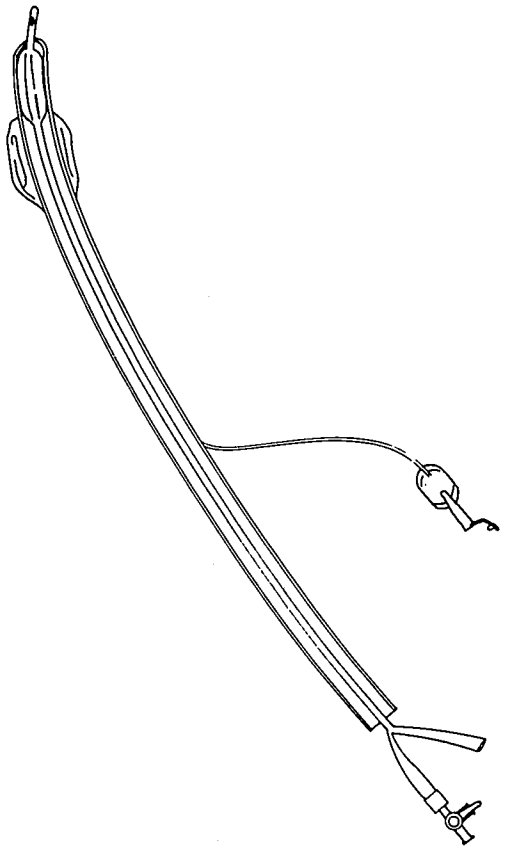

FIG. 1. A balloon catheter placed in the nasotracheal tube.

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Concepts of Thiopental Distribution and Metabolism, Old and New

To the Editor:—In a recent issue, Burch and Stanski report a study of thiopental (TPL) pharmacokinetics with frequent early arterial blood collection.[1] This study was done to ascertain the relative importance of redistribution and metabolism in recovery from TPL anesthesia. They reached opposite conclusions than those of Saidman and Eger, who used physiologic modeling to answer the same question 15 years ago.[2] As these two reports represent different approaches to the same question, I compared them further.

For the comparison, I recreated the model of Saidman and Eger on a digital computer. I then simulated blood TPL levels following a 6 mg/kg bolus injection at the blood collection times used by Burch and Stanski. Also, the metabolic loss/total ratio as defined by Burch was calculated from the simulations. Two simulations were done; one assuming a hepatic extraction ratio of 0.15, which is close to the accepted value and one assuming a hepatic extraction ratio of 0.30, which was the value used by Saidman and Eger for their conclusions.

The simulated blood levels assuming a hepatic extraction ratio of 0.15 are almost identical to the mean values reported by Burch and Stanski from the time period of 1–15 min. Also, simulated blood levels assuming a