

Anesthesiology  
70:883, 1989

### An Unusual Cause of Endotracheal Tube Obstruction

*To the Editor:*—A 1,300-g neonate requiring ventilatory support was intubated with a 2.5-mm endotracheal tube containing a new disposable, plastic-sheathed stylet. Upon removing the stylet with some difficulty and attaching the endotracheal tube to the breathing circuit, ventilation was attempted but impossible. Immediate laryngoscopy confirmed correct position of the tube through the larynx. Rapid transillumination of both lung fields revealed no evidence of tension pneumothorax. Replacement with a new endotracheal tube provided effective ventilation.

Examination of the first tube revealed the lumen to be clogged by the distal sheared-off portion of the plastic sheath surrounding the metal stylette (fig. 1). The stylet was a new, unused 6-French Satin-Slip™ intubating stylette with lubrication recommended for tracheal tube sizes 2.5–4.5 mm. The sheathed stylet tube fitting was snug, and we suggest caution be used with sheathed stylets used for small lumen endotracheal tubes, with unsheathed stylets or no stylets being the other option.

WALTER P. ZMYSLOWSKI, M.D.  
*Assistant Clinical Professor of Anesthesia*

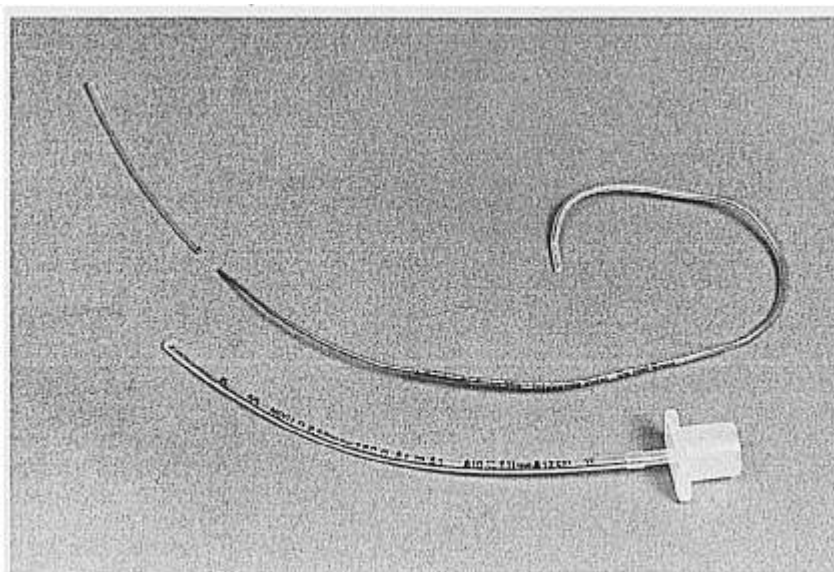
DAVID KAM, D.M.D., M.D.  
*Chief Resident in Otolaryngology*

GEORGE T. SIMPSON, M.D.  
*Professor Otolaryngology  
Director of Otolaryngology*

*Boston University School of Medicine  
Boston City Hospital  
818 Harrison Avenue  
Boston, Massachusetts 02118*

(Accepted for publication February 7, 1989.)

FIG. 1. Endotracheal tube and stylet showing the sheared-off portion of the plastic sheath surrounding the metal stylet.



Anesthesiology  
70:883–884, 1989

### A Problem with Metal Endotracheal Tubes and Plastic-coated Stylets

*To the Editor:*—Metal endotracheal tubes are used during laser endoscopic surgery to reduce the risk of airway fires.<sup>1</sup> These tubes are flexible and generally require the use of a stylet to facilitate intubation. Recently, we have become aware of a problem that can occur when plastic-coated stylets are used with metal endotracheal tubes. The presence of bends or sharp curves in the stylet when inserted into the metal tube may not only make it difficult to remove the stylet at the appropriate time, but, more importantly, during stylet removal, pieces of the plastic coating may be scraped from the surface by the metal edges of the inside of the tube. These plastic pieces may be forced into

the airways during positive-pressure ventilation and act as foreign bodies in the lungs. This problem can be avoided by making sure that there are no sharp bends or kinks in the stylet before insertion into the metal endotracheal tube and by testing the stylet for easy removal from the tube.

CHRISTOPHER E. LARSON, D.M.D., M.D.  
*Resident  
Department of Anesthesiology  
University of Pittsburgh School of Medicine*

RENE M. GONZALEZ, M.D.  
Assistant Professor  
Department of Anesthesiology  
University of Pittsburgh School of Medicine  
Anesthesiologist-In-Chief  
Eye and Ear Hospital

230 Lothrop Street  
Pittsburgh, Pennsylvania 15213

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(Accepted for publication February 7, 1989.)

Anesthesiology  
70:884, 1989

### Pulse Oximetry is Presently Not an American Society of Anesthesiologists Standard

*To the Editor:*—The current *Standards for Basis Intra-Operative Monitoring*, approved by the House of Delegates of the American Society of Anesthesiologists, October 21, 1986, in the section Oxygenation, states, “. . . quantitative methods, such as pulse oximetry . . . are encouraged.” This is in conflict with the opening sentence in the article by Tremper and Barker<sup>1</sup> which states, “Pulse oximetry has been recommended as a standard for care for every general anesthetic,” citing the ASA document as a source of the statement.

BURTON S. EPSTEIN, M.D.  
Chairman, Committee on Standards

American Society of Anesthesiologists  
Department of Anesthesiology  
George Washington University  
23rd Street, N.W.  
Washington, DC 20037

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1. Tremper KK, Barker SJ: Pulse oximetry. *ANESTHESIOLOGY* 70:98-108, 1989

(Accepted for publication February 16, 1989.)

Anesthesiology  
70:884, 1989

*In Reply:*—We stand corrected. The House of Delegates of the American Society of Anesthesiologists merely “encouraged” the use of quantitative measures of oxygenation such as pulse oximetry. Encouraged means to “give support to or foster,” whereas recommend means “to counsel or advise,” the latter being construed as a stronger term.<sup>1</sup> Perhaps it would have been more appropriate for us to have referenced an editorial appearing in *ANESTHESIOLOGY* last year which stated, “We believe that pulse oximetry should become a part of the routine monitoring of all patients undergoing general anesthesia . . .”<sup>2</sup>

KEVIN K. TREMPER, PH.D., M.D.  
Chairman, Department of Anesthesiology  
Associate Professor of Anesthesiology

STEVEN J. BARKER, PH.D., M.D.  
Associate Professor of Anesthesiology

University of California, Irvine  
UCI Medical Center  
Mail Route 81A  
101 City Drive South  
Orange, California 92668

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1. The American Heritage Dictionary of the English Language. Edited by Morris W. New York, American Heritage Publishing Company, 1969
2. Cohen DE, Downes JJ, Raphaely RC: What difference does pulse oximetry make? *ANESTHESIOLOGY* 68:181-183, 1988

(Accepted for publication February 16, 1989.)