A METHOD OF PASSING RYLE'S TUBES
IN ANÆSTHETIZED PATIENTS

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The indications for gastric aspiration before and after operation are well-established, and for some operations it is usual to bring the patient to the theatre with a Ryle’s tube in position. However, it is not rare for the anesthetist to be requested to pass a Ryle’s tube during the course of an operation, either because the need for it has only been made evident by operative findings, or because the tube passed beforehand has become displaced or blocked.

The common method of attempting to insert a Ryle’s tube in an unconscious subject is to pass a laryngoscope and then, with a Magill’s forceps, to coax the tube, an inch or two at a time, down the oesophagus. Even if all goes well this is an awkward procedure, especially if one has to burrow under the sterile towels; and quite often, even with normal dexterity, the tube being slippery with lubricant and softened by repeated boiling, there is nothing to show, at the end of all, but an abraded pharynx with a tube curled up in it.

There is, however, a quick, easy, certain, and atraumatic method of performing the requisite manoeuvre, which, although very simple, does not appear to be well known. This is to insert, either “blind” or with the aid of a laryngoscope, a Magill’s endotracheal tube (about No. 8 is most convenient) through the mouth into the oesophagus. The Ryle’s tube is then passed well into the stomach down
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through the Magill's tube; if the inside of the latter be freely lubricated this can always be done very easily.

To remove the Magill's tube, one withdraws it until its tip is in the pharynx, and grasps the Ryle's tube just above the oesophageal opening, either digitally or, under laryngoscopic vision, with Magill's forceps; this enables the Ryle's tube to be held steady while the Magill's tube is slid back over it and removed.

If, as is usual, one desires to have the tube passing through the nose rather than the mouth, a nasal Magill's tube (about No. 5 for choice) is later inserted through the nose into the pharynx and its tip drawn out through the mouth. Into the lumen of its distal end is pressed the proximal end of the Ryle's tube, bent double for two inches or so, and withdrawal of the Magill's tube from the nose then brings the Ryle's tube to lie in the required position.

These manipulations sound complicated, but each step can be performed rapidly, simply, and without trauma. It is better to perform the manoeuvre by stages than to start by passing the first Magill's tube through the nose into the oesophagus. The latter procedure is by no means so simple as to pass it through the mouth, and has the added disadvantage that a Magill's tube wide enough to take the Ryle's tube easily may cause trauma in the nose.

The presence or absence of an endotracheal tube for the anaesthetic does not appreciably affect the ease of the manoeuvre, which might also be found useful in the management of patients unconscious from causes other than anaesthesia.

In describing his "new gastro-duodenal catheter" (which is manufactured in about the same range of diameters, 4–5.5 mm., as the Ryle's tube more commonly used...
in this country) Levin (1921) claimed that “it can easily be introduced through the nose even when the patient is under anaesthesia”. However, the general opinion has persisted that “in the absence of the swallowing reflex this may be difficult” (Conroy, 1943). Lundy (1942) and Conroy (1943) reported successful insertion of Levin-type tubes in unconscious patients both by means of laryngoscope and Magill’s forceps, and by preliminary introduction of a naso-oesophageal Magill’s tube; Conroy also recommended passing the Levin tube blind through the nose, imparting rigidity to it in its pharyngeal course and directing it into the oesophagus with a finger inserted into the pharynx. Some disadvantages of the first two of these methods have been indicated above, and the writer has not found any of them so reliable, for Ryle’s tubes, as the method here advocated, which most surely overcomes the tendency of the tube to coil in the pharynx. Lundy (1942) “found it necessary” to use the method, which he described clearly, “in one instance” when his other, usually successful, methods had failed.

No consideration here put forward affects the universally agreed necessity of emptying the stomach with a full-sized stomach-tube before anaesthesia in cases of acute intestinal obstruction. Of course the full-sized tube can always be passed fairly easily whether the patient be anaesthetised or not, and should always be preferred if the gastric contents are too copious or too thick to be aspirated easily through a Ryle’s tube. The advantage of the latter in the circumstances outlined are that it is better tolerated during recovery of consciousness and afterwards; and ward-sisters are pleased, when a Ryle’s tube is needed after operation, if the patient returns from the theatre with one already in place.
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I am indebted to Dr. Ernest Landau and Dr. R. F. Woolmer for helpful criticisms.

REFERENCES

Conroy, W. Allen (1943), *Anesthesiology*, 1, 81.