LEAKING CUFFED ENDOTRACHEAL TUBES: TWO CASE REPORTS

Sir,—Separation of cuffs of endotracheal tubes at the glued margins, though rare as compared to rupture of cuffs, may be worth documenting. One may be confronted with the dangers of aspiration of irritant gastric contents into the lungs due to such a leak developing suddenly in the cuff, in the course of an operation.

Case 1. A new Magill cuffed oral endotracheal tube size 8 was used during anaesthesia for an emergency operation for strangulated femoral hernia. The integrity of the cuff was tested before use. During the course of the operation, a hissing sound arising in the pharynx led the anaesthetist to check the cuff by pressing the cuff-inflator. The cuff was found to leak. Immediate laryngoscopy revealed the collapsed cuff. After thorough pharyngeal suction the tube was replaced and the operation continued to the end without further difficulty. Inspection of the faulty endotracheal tube revealed that no part of it was missing; the cuff was perfectly intact, although it could not be inflated. Attempts at inflation when the tube was immersed in water showed air bubbling through the distal cuff-margin. There was a length of 0.5 cm of the distal attached margin of the cuff where the glue had given way.

Case 2. During anaesthesia for a lower segment Caesarean section, a similar new cuffed rubber oral endotracheal tube size 8 was used, when the cuff suddenly deflated in the middle of the operation. After replacement with another tube, inspection revealed an area of separation of the distal border of the cuff for 0.4 cm which had resulted in spontaneous deflation. Separation or giving way of the attached margins of cuffed endotracheal tubes, though rare, has not been well documented. Though the fault does not constitute so serious a danger as in the case of a missing piece of cuff (as reported by Doyle and Conway, 1967, and Divekar, 1967) nevertheless there is the possibility of acid gastric contents being aspirated into the lungs.

S. K. DEBNATH
D. J. WATERS
Gloucester

REFERENCES

"PRINCIPLES AND PRACTICE OF OBSTETRIC ANALGESIA AND ANESTHESIA"

Sir,—It is impossible for us to refrain from commenting on the criticism made by Dr. J. Selwyn Crawford of Dr. John Bonica’s book Principles and Practice of Obstetric Analgesia and Anesthesia, Vol. 1, which appeared in the British Journal of Anaesthesia, Vol. 40, No. 1, January 1968. We work in one of the biggest obstetrical hospitals in Mexico City with more than 20,000 deliveries a year and a teaching department, and feel in a position to make some comments.

We have the two editions of Dr. Selwyn Crawford’s excellent book Principles and Practice of Obstetric Anaesthesia, and find it unbelievable that such an eminent writer could make destructive and unjust comments. Contradicting his own printed views, Dr. Crawford here apparently denies the importance of anaesthesiologist’s care of the pregnant woman and her baby during labour and delivery.

Dr. Crawford objects to the high cost of the book; we, who live in a so-called “underdeveloped” country, find his work too important for us not to make the effort of buying it; likewise most of the obstetricians in our hospital.

We believe as anaesthesiologists that all of our colleagues, regardless of country, deserve respect and consideration. This is specially true in the case of Dr. John J. Bonica. His Principles and Practice of Obstetric Analgesia and Anesthesia is a real masterpiece that represents his life’s devotion to the subject.

FERNANDO RODRIGUEZ
Mexico City, Mexico

DEXTAVEN: A DISCLAIMER

Sir.—In the July issue of the Journal a paper by Dr. J. R. Maltby (Brit. J. Anaesth., 1968, 40, 552) names this company as the manufacturers of the dextran product Dextraven, to which his patient developed an anaphylactic reaction.

I must point out, and would be grateful if you would make a note, that Dextraven is not manufactured by Glaxo.

R. J. WRIGHTON
Glaxo Laboratories Ltd.

TRILENE INTERLOCK UNIT

Sir.—The hazardous product of soda-lime and trichloroethylene is not—as I inadvertently put in my letter about the Trilene interlock unit in the September issue (p. 701)—dichloroethylene, but dichloroacetylene.

Apologies for this error.

D. M. JACKSON
Northampton