


Sir,—It is generally accepted that lung function is impaired after surgery under general anaesthesia. "Sighing" had its brief heyday. Is it now the turn of positive end expiratory pressure (PEEP), although at one time any respiratory obstruction was frowned on? Should we use this manoeuvre throughout general anaesthesia, or at least towards its termination until its value in this context has been elucidated? Increasing the tension on the expiratory valve, during both controlled and spontaneous ventilation, would be one method. Perhaps, as usual, someone has already tried it!

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Sir,—Anaesthetists have difficulty occasionally in inserting a nasogastric tube during anaesthesia. Several methods have been proposed (Steen, 1964; Ogawa, 1970; Tahir and Adriani, 1971) but these are complicated and somewhat traumatic. The method described here is simple and reliable and needs no expensive equipment.

A guitar string (E) is well lubricated and is introduced into the lumen of a nasogastric tube. The tubing must be cold so that it is shorter than the string by 10 cm. The well-lubricated nasogastric tube so prepared is introduced through a nostril gently and advanced smoothly through the oesophagus to the stomach. Correct location of the tube is confirmed with aspiration of gastric contents through the oesophagus to the stomach. Correct location is then taken over slowly while the nasogastric tube is held tightly with the other hand. It takes about a minute from the insertion to the withdrawal of the guitar string. This method is very simple and there have been few instances of nasal bleeding and other complications which are often observed with the other methods. This method can be adapted for children when a smaller gastric tube and guitar string are used.

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A potential danger

Sir,—I think it right that I should draw the attention of your readers to a problem encountered with Vickers/Puritan flowmeters.

Owing to a design fault in the upper end of the flowmeter, it is possible for a spur, which prevents the flowmeter bobbin from blocking the exit orifice, to break off and thus allow the bobbin to impinge upon the outlet orifice. This, of course, cuts off the flow of oxygen through the device.

The harder you turn on the tap the more certain it is that no flow will occur, although the pressure of oxygen on the proximal side of the bobbin holds it up, maintaining the unsatisfactory state of affairs while giving the appearance that a very high flow rate is occurring.

The attention of the representative of the firm producing this flowmeter has been drawn to the problem and I am sure that they are taking measures to deal with it, but it is important that those using this flowmeter should be aware of the potential hazards some of the older models may present.

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