Sinus arrest occurred 17 min after first administration of vecuronium.

After administration of atropine, two further doses of vecuronium did not produce disturbance of rhythm.

After having considered the above points, do the authors really think that vecuronium had any responsibility in the sinus arrest they reported?

E. MAESTRONE
G. PRADELLA
Sondrio

REFERENCE

Sir,—Thank you for giving me the opportunity to reply to the points raised by Drs Maestrone and Pradella.

It was not intended to suggest vecuronium was responsible per se for the sinus arrest. The case was reported to emphasize that anaesthesia using agents known to cause bradycardia, such as opiates and halothane, in conjunction with so-called "clean" myoneural blockers such as vecuronium and atracurium, may result in bradycardia which may be severe, or even, as in this patient, sinus arrest.

In common with many anaesthetists in the U.K., it has not been my practice to prescribe atropine routinely as part of premedication for some time. Atropine is, however, kept at hand so that small but suitable doses may be given i.v. to obtain the correct degree of block of the cardiac vagus, indicated by continuous ECG monitoring. This assumes particular importance when a neuromuscular blocking drug devoid of cardiac side-effects, such as vecuronium, is used, and bradycardia caused by other drugs is uninhibited and may be severe.

The report of this case was intended to draw attention to these points.

I. KIRKWOOD
Glasgow

DIFFICULT INTUBATION

Sir,—A gum-elastic bougie can be a valuable aid to the intubation of the trachea when the larynx is difficult to see, and when anatomical factors prevent the tube from being directed into the trachea. However, after successful passage of a bougie it may be difficult or impossible to slide the tube around it (Boys, 1983). When the tube is simply pushed down around the bougie lying in the trachea (fig. 1a) the tip of the tube is liable to lodge on the right vocal cord. Encountering resistance, one automatically tends to rotate it clockwise, as if inserting a bolt or screw, thus causing the tip of the tube to lie posterior to the bougie, protruding like a ploughshare (fig. 1b) lodging firmly behind the arytenoids. I suggest that, before the tube nears the larynx, it should be rotated a quarter-turn anti-clockwise. This manoeuvre will cause the tip of the tube to lie anterior to the bougie, and to be in close contact with the bougie, so that it does not catch on anything (fig. 1c). The tube must previously have been lubricated inside and outside.

I have tested this technique in more than 100 patients, some of whom would otherwise have been difficult to manage, and have found it has always been successful and atraumatic.

The quarter-turn anti-clockwise twist of the tube on the bougie is applicable also to nasal intubation. Perhaps it would be helpful in "guided blind intubation" when the tube tends to slip into the oesophagus (Akinyemi and John, 1974).

P. S. COSSHAM
Leicester

REFERENCES