CORRESPONDENCE

JOURNALS FOR POLAND

Sir,—May I appeal through your columns for any back numbers of British Journal of Anaesthesia from January 1982 to December 1988. These would be transferred to the University Hospital Krakow in Poland, where it has not been possible to obtain the British anaesthetic journals since January 1982.

Any of your readers who are in a position to help should contact me at the following address:
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I shall, of course, be happy to arrange transport of any issues.

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AIRWAYS RE-REVISITED

Sir,—“Airways Revisited” [1] implied that transtracheal ventilation is unethical. However, it is a valuable tool with which to guarantee oxygenation in those patients who have very difficult airways [2]. A 13-gauge cannula (Trans Cricothyrotomy Device, VBM) placed through the cricothyroid membrane to provide oxygen provides security for patient and anaesthetist, so that attempts at fibreoptic intubation need not be hurried for fear of desaturation [3]. Puncturing the membrane to inject local anaesthetic is accepted practice—why not inject oxygen?

Blind nasal intubation is conspicuously absent from the editorial. Fibreoptic placement of a tube seems a logical alternative, and both are less hazardous with a cricothyroid needle to provide oxygen or to bypass the problem airway altogether.

Anaesthetists wishing to achieve a great degree of skill at fibreoptic intubation need to practise extensively. This begs the question: is it ethical to try to pass tubes in normal anaesthetized patients, using fibreoptic techniques, without their informed consent?

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REFERENCES

Sir—We wish to comment on two aspects of the editorial [1] relating to our article describing a Standard Intubating Position. The first relates to whether or not this position should be regarded as “optimum”. It was not our intention to give this impression and we provided no evidence for this view. Our approach to difficult intubation is to determine the requirements for a reproducible definition. While difficulty is often defined in terms of what is seen at laryngoscopy [2, 3], this neglects the important question of technique. For example, if the less experienced fail to achieve the same laryngeal exposure as senior anaesthetists, attention needs to be directed at why this should be so.

The second matter is the reference to tactile tests [4, 5]. Capnographs and fibreoptic bronchoscopes are expensive and, even in well equipped institutions, are not always present. Equipment may fail at a crucial moment, with insufficient time for substitution, therefore clinical tests continue to be useful. After more than 2 years’ experience with tactile tests, we are convinced that, in the same way that most anaesthetists regard “seeing is believing” as proof of tracheal intubation, a similar philosophy is appropriate for palpation, although a well-practised technique is important.

We find some difficulty with the implication that infection is a problem with tactile and aspiration tests but not with fibreoptic bronchoscopes or capnographs. Any equipment may become contaminated and careful technique is always appropriate. Details such as attention to sharp teeth and the use of theatre gloves rather than thin plastic gloves are appropriate. It would be unfortunate if the specialty took the view that tactile tests pose too great a risk to anaesthetists while surgeons continue to perform PR and PV examinations. In the latter case the information provided is diagnostic, while in the former it may prove vital.

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REFERENCES