the lungs of a patient who has a tube in the oesophagus if the proximal end of the tube is brought under the rim of the face masks.

In patients with limited mouth opening, our technique may be easier than insertion of the Oesophageal Vent-Laryngeal Mask, as the oesophageal tube can be moved over to the left side of the mouth. Clearly, further assessment and comparison of these techniques in cases of difficult and failed tracheal intubation would be interesting.

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Sir,—The modified laryngeal mask described by Akhtar [1] reflects a line of enquiry pursued by the inventor of the laryngeal mask airway (LMA) between 1983 and 1987. Figure 1 shows one of the patented designs, which closely resembles Akhtar's modification, but has a communication between the two cuffs, permitting simultaneous inflation from a single inflation port. The modification, but has a communication between the two cuffs, permitting simultaneous inflation from a single inflation port. The device, which was made entirely from silicone, can be seen in the LMA Museum at the Royal Berkshire Hospital, Reading. The reasons for not continuing with this development may be of interest. The addition of an integral oesophageal tube increases the difficulty of insertion, the invasiveness of the procedure and the complexity (and hence the likely price) of the device. Such a development therefore is not likely to be attractive as a general-purpose airway. If it is desired to pass a tube into the oesophagus, this can be done easily after placing a standard LMA using a well-lubricated tracheal tube. The LMA is only moderately inflated (for example 25 ml in a size 4) and the tracheal tube is passed blindly and gently with the head extended. Not only is this easier, but there is a further advantage in that the mask serves to shield the glottis from the tube as the latter is passed downwards, guiding it into the upper oesophageal sphincter. A characteristic pressure is felt as the tube encounters and passes through the sphincter, so that it is not difficult to judge the level of tube placement.

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Sir,—Thank you for the opportunity to reply to the comments made on the Oesophageal Vent-Laryngeal Mask. The device described is only a prototype that requires refinement to allow better conformation to the oropharyngeal anatomy which could make placement no more difficult than the standard laryngeal mask airway (LMA).

I note Dr Brain's comments but remember him describing a new modification of the LMA that has a tube attached to the dorsum of the LMA (not penetrating the oesophagus) for the drainage of regurgitated contents, at a conference on “The Use of Laryngeal Mask for Resuscitation” in London, January 13, 1994. Hiccups under general anaesthesia may increase the incidence of regurgitation but two patients that hiccuped in my study did not regurgitate. The presence of the LMA anterior to the oesophageal tube encourages it to slide along the posterior wall of the pharynx and the oesophagus, making tracheal intubation most unlikely. Search for a better design of the LMA (and various other techniques) to prevent regurgitation however continues.

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Ferrous distortion during MRI

Sir,—The presence of ferromagnetic material in the proximity of magnets during magnetic resonance imaging (MRI) may produce unwanted interference and degradation of image quality [1]. Standard tracheal tubes may become kinked in patients undergoing head and neck procedures or in association with changes in patient position. Reinforced tracheal tubes are used in these situations to prevent intraoperative hypoxaemia and increases in airway pressure. We report a case of image distortion caused by a stainless steel reinforced tracheal tube. A 49-yr-old female presented for stereotactic biopsy of a right temporal space-occupying lesion. Anaesthesia was induced with fentanyl 2 μg kg⁻¹ and thiopentone 4 mg kg⁻¹ and vecuronium 0.1 mg kg⁻¹ was administered to facilitate tracheal intubation with a 7.5-mm cuffed reinforced tracheal tube. Anaesthesia was maintained with nitrous oxide and isoflurane in oxygen and normocapnic controlled ventilation. A stereotactic frame was applied and imaging commenced. However, marked image distortion was observed. A biopsy specimen of the targeted lesion was reported as normal brain tissue. An open brain biopsy was required to obtain histological specimens which revealed glioblastoma multiforme.

This is the first reported case of a reinforced tracheal tube producing image distortion during an MRI procedure. Image distortion associated with armoured tracheal tubes has major clinical implications. We suggest the use of a nylon reinforced tube when a non-kinkable tube is indicated during MRI procedures. Extra anaesthetic vigilance is warranted because such tubes may be more prone to kinking. This case report confirms previous experience that any metal object, if sufficiently close to the region to be scanned, may cause image distortion [2].

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