Correspondence

Difficulty in advancing a tracheal tube over a fibreoptic bronchoscope: incidence, causes and solutions

Editor—Asai and Shingu¹ should be congratulated on their thorough and informative review of the vexing problem of how best to advance a tracheal tube (TT) over a fibrescope that has been correctly positioned in the trachea. Indeed, junior endoscopists are often frustrated by their inability to perform what they wrongly believe to be the easy part of the fibreoptic intubation sequence: railroading the tube—the nuances of which can be as subtle and exacting as any other part of the procedure. We have used three approaches not mentioned in the article to deal with problems at this point in the intubation process.

First, increasing the size of the target area the TT must negotiate (i.e. dilating the laryngeal introitus and supra-glottis). This can be done by asking the patient to take a deep breath when the tube is advanced or similarly, advancing the tube on inspiration. Patient compliance is assured by using minimal sedation and topical anaesthesia. Equally, in spontaneously breathing anaesthetized patients, tube advancement should be synchronized to the inspiratory phase.

Second, personal experience is that it is more straightforward to advance a TT when an awake patient is sitting upright than when recumbent. This may relate to optimal positioning of the head and neck and is the position mandated by many patients who have jeopardized airways.

Lastly, although Asai and Shingu refer to flexing the patient’s neck, full optimization of the airway may be facilitated by asking a sitting patient to look upwards; they automatically adopt a posture to ‘sniff the morning air’, which, again, seems to minimize hold-up of the TT.

So, as Asai and Shingu eloquently point out, there are many evidenced-based manoeuvres and pieces of equipment that are used to advance TTs over fibrescopes, but we must never forget that the patient can be of vital help too.

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Methicillin-resistant Staphylococcus aureus in the critically ill

Editor—We read with great interest the review article on MRSA in the critically ill,¹ in which the authors stressed the high risk of infection in intensive care patients. Recently, we presented the case of a patient who died in our ITU, at our hospital’s grand round. We gave his cause of death on the death certificate as methicillin-resistant Staphylococcus aureus (MRSA) septicaemia secondary to MRSA pneumonia. The 47-yr-old patient had a previous history of controlled asthma. He had had no hospital treatment in the past. He needed level 3 critical care treatment after acute deterioration in his asthma control attributable to a presumed viral infection, and was transferred to our unit. His admission MRSA screen was negative. Subsequently he developed septic shock and multi-organ failure. A chest x-ray showed new infiltrates consistent with hospital-acquired pneumonia and sputum and blood cultures grew MRSA. He died 16 days after admission despite treatment with vancomycin, fusidic acid and rifampicin. Post-mortem examination showed bilateral multiple small lung abscesses consistent with staphylococcal infection. MRSA was grown from these.

Your review article has highlighted the issue of MRSA as a primary cause of death in critical care that is being increasingly reported and has helped us in documenting our case. We have also been able to stress upon our hospital colleagues that intensive care patients have a combination of risk factors that makes them especially prone to nosocomial infection and the Critical Care Unit in any hospital will continue to have the highest infection rates, particularly with MRSA (Fig. 1). We also believe that scrupulous

Fig 1 New MRSA isolates 2003–2004. *Denotes more than one ward.