revealed a tumour in the small bowel mesentery with adherent loops of small bowel, which on histological examination was found to be lymphoma. The stomach, duodenum and jejunum were dilated. The lungs showed signs consistent with adult respiratory distress syndrome.

This case reinforces the importance of systematic preoperative assessment as previously advocated,1 bearing in mind the possibility of systemic involvement from disease processes. Despite the resolution of gastrointestinal symptoms, our patient was still at risk of aspiration.

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1 Asai T. Who is at increased risk of pulmonary aspiration? Br J Anaesth 2004; 93: 497–500

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CEMACH report: oesophageal intubation

Editor—Drs Cooper and McClure rightly highlight the worrying re-emergence of unrecognized oesophageal intubation as a cause of death in Why Mothers Die 2000–2002.1

I gave my first (supervised) obstetric anaesthetics in 1963. Detailed anaesthetic records were not kept routinely but I was taught to use the record card, designed (I believe) by Dr Michael Nosworthy, whenever problems arose. This masterpiece of compression provided a time chart for vital signs with preprinted options for selection denoting drugs, techniques, complications, etc. I asked my consultant what was meant by ‘under mask’ in relation to tracheal intubation and was told that before proper connectors became available it was customary to assist ventilation by placing a face mask over the endotracheal tube. Obviously the ventilation route would be oropharyngeal if the tracheal tube was wrongly sited. I used this system in certain circumstances when I had doubt about the correct placement of a tube but had had such difficulty with laryngoscopy that I found myself reluctant to remove a tube. I have subsequently always rejected the simplistic maxim ‘when in doubt, take it out’ in debates on recognition and management of airway problems.

Years later this method saved a patient’s life when I was called by nursing staff to a theatre where a patient was clearly in extremis but a colleague would not entertain the possibility of a misplaced endotracheal tube. Patency had been checked and bronchodilators given. Disconnecting the breathing system from the tube, adding a face mask and using this to hand ventilate transformed the patient’s colour and chest movements. Diagnosis and treatment were simultaneous.

It would have been psychologically (and hence physically) extremely difficult to have used any other approach and I believe the psychology of this type of situation has been seriously neglected. The mortality report comments ‘in all these cases, there appeared to be a major reluctance on the part of the anaesthetist to consider the possibility that the oesophagus had been intubated in error’. One had hoped that the introduction of reliable monitoring (one of the constant joys of my later days in anaesthetic practice) would have eliminated these problems, nevertheless information is only part of the battle, a manoeuvre that simultaneously diagnoses and treats a problem is worth remembering.

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Nasotracheal intubation

Editor—we read with interest Piepho and colleagues’ description of a traumatic nasotracheal intubation (NTI) in a patient with an unanticipated difficult airway.1 We would like to suggest an addendum to Piepho’s algorithm for NTI.

Any algorithm for NTI should include anticipated difficult airways. We feel this is pertinent as the nasal route is often used in cases with inadequate mouth opening and for oral and maxillofacial surgery. We have previously described the airway management with NTI in patients with anticipated difficult airways.2

In the ‘NTI in anticipated difficult airway’ algorithm, we too like to look before we leap! First, we assess the airway under anaesthesia. When NTI is used for potentially difficult airways, it is important to maintain spontaneous ventilation.3 A preliminary laryngoscopic view under anaesthesia is useful for patients with adequate mouth opening.4 In Piepho’s algorithm, ‘direct laryngoscopy’ could be renamed ‘preliminary laryngoscopy’. If the view is Cormack–Lehane (CL) 1 or 2, the plane of anaesthesia is further deepened using i.v. or volatile anaesthetic agents. Intubating laryngoscopy and tracheal intubation follows. NTI has been successfully performed without neuromuscular blockade.5 If the view is CL 3 or 4 or if laryngoscopy cannot be performed, the alternatives suggested by Piepho can be adopted.

The nasal cavity evaluation can also be carried out under anaesthesia; best immediately after the preliminary laryngoscopy. The apparently more patent nostril would have been already selected preoperatively by the airway patency test5 and suitable vasoconstrictors applied. If the nasal passage seems unsuitable for tracheal tube passage then the oral route or submental route may be used. Smith and Reid6 found a high incidence of intranasal pathologies (68% of their patients) that would make nasotracheal intubation difficult and have suggested fiberoptic intubation to select the best nostril. However, they add that despite major abnormalities, these patients do not sustain serious injury more frequently during intubation. We agree with their opinion that with experience, anaesthetists develop an acute sense of how much pressure they can apply on the tracheal tube before they abandon it for the other nostril.

Because of bleeding, Piepho and colleagues found themselves dealing with a dangerously difficult airway,7 possibly because they attempted NTI in a single step. Successful nasotracheal intubation, as described in their and other8 algorithms, consists of three important steps—adequate laryngoscopic views, atraumatic nasopharyngeal intubation, and passage of the tube into the trachea.

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