To the Editor:—May I comment about the case report on a complication of nasal intubation by Andrea R. Williams et al. on page 1782 in the June 1999 issue of ANESTHESIOLOGY.1 This report describes an accidental middle turbinectomy during a nasal tracheal intubation. The authors note that lack of topical vasoconstriction may have contributed to the injury. There is another factor that should be considered before nasal intubation. In a large proportion of such patients, one nasal passage is smaller than the other. Thus, there is a 50% chance of inserting a nasal tracheal tube in the narrower of the two. Having the patient sniff and inspection of the nares will not always reveal the narrower of the two passages. There is a maneuver performed before nasal intubation that could shrink the mucous membrane as well as reveal the narrower of the two passages. It was taught to the anesthesia staff at Grasslands Hospital in Westchester, New York by our chief, Harold Bishop in the 1960s. I don’t think he claimed originality.

Two 6-inch cotton-tipped applicator sticks were dipped in neosynephrine (cocaine if an awake intubation was planned). Each cotton tipped stick was slid posterior along the floor of the nose. The mucosa was shrunk and palpation clearly revealed which passage was more patent. Obviously a wider passage will make an easier intubation with fewer complications.

Martin Livingston, M.D.
Honorary Attending Anesthesiologist
New York Eye and Ear Infirmary
New York, New York

Reference


(Accepted for publication December 2, 1999.)
tube cephalad (fig. 1), more likely than not directs its bevel and tip away from the turbinates and promotes their passing between the inferior turbinate and the nasal surface of the palate where the nasal passage is the largest. This, in itself, avoids turbinectomy even with a REA tube which if not pulled cephalad is likely to be directed at the turbinates.

Daniel C. Moore, M.D.
Emeritus
Department of Anesthesiology
Virginia Mason Medical Center
Seattle, Washington

References
2. Cooper R: Bloodless turbinectomy following blind nasal intubation. Anesthesiology 1989; 71:469
3. Moore DC, Cooper R: Bloodless turbinectomy following blind nasal intubation: faulty technique (letters)? Anesthesiology 1990; 73:1057
5. Sessler CN, Vitaliti JC, Cooper KR, Jones JR, Powell KD, Pesko LJ: Comparison of 4% lidocaine/0.5% phenylephrine with 5% cocaine: which dilates the nasal passages better. Anesthesiology 1986; 64:274–77

(Accepted for publication December 2, 1999.)

Anesthesiology
2000; 92:1505
© 2000 American Society of Anesthesiologists, Inc.
Lippincott Williams & Wilkins, Inc.


To the Editor—Anatomically speaking, physicians often use the more “proper” Latin names instead of the more common lay terms. If one chooses the former, care must be taken to do so correctly.

In an otherwise clear and informative case report, the authors referred to the “left nares” and the “right nares” of a nasally intubated patient. Unless the patient in question had four or more nostrils, this usage was incorrect. One naris plus another naris makes two nares.

Craig S. Jenkins, M.D.
Senior Attending Anesthesiologist
Department of Anesthesiology
Riverside/Grant Hospitals
Columbus, Ohio
jinxed@columbus.rr.com

(Accepted for publication September 14, 1999.)

Anesthesiology
2000; 92:1505–6
© 2000 American Society of Anesthesiologists, Inc.
Lippincott Williams & Wilkins, Inc.

Arytenoid Subluxation Caused by Laryngoscopy and Intubation

To the Editor—I would like to question the conclusion of Paulsen et al., that “laryngeal trauma caused by tracheal intubation does not cause subluxation of arytenoid cartilage.”1 Whereas they found the forces from endotracheal tube manipulations and “manual squeezing” of the arytenoid produced no subluxation, it is unclear whether the “manual squeezing” described produced simple compression of the tissues, actual arytenoid displacement, or equalled the forces of laryngoscopy. Their study may exclude forces from singular endotracheal tube place-

Anesthesiology, V 92, No 5, May 2000