
(Accepted for publication February 7, 2000.)

CORRESPONDENCE

In Reply—The suggestion by Candido et al.1 to change the words in the title of my editorial from "Potential Great Danger" to "Prohibitive Danger" is the result of a poor risk-benefit analysis. No one disputes the great benefit and small risk of having a stylet already in situ in the trachea should the planned or unplanned need for reintubation arise ("simple concept"). What is disputed is the risk-benefit of using the stylet for jet ventilation. The benefit of having a safe ventilatory and oxygenating mechanism already in situ in the trachea in case reintubation is unsuccessful is also obvious ("simple concept"). My editorial simply pointed out the many ways in which the risk of jet ventilation can be greatly increased and, conversely, the many ways in which the risk of jet ventilation can be greatly decreased. Therefore, if one jets with a 25-psi and 0.5-s inspiratory time through a relatively small airway exchange catheter (AEC) inserted no more than 26 cm in an adult, the ventilation risk is small. Figure 1 and the legend of figure 1 of the letter to the editor by Candido et al., which shows some displacement of subcutaneous tissue caused by a sustained 0.25-psi jet from a large AEC, is misleading because the arm is richly endowed with adipose tissue and the flows over a very short period of time from this system are well-known.2 The tidal volume from a 25-psi, 0.5-s jet from a large AEC into a lung with static compliance of 50 ml/cm H2O is approximately 350-400 ml.2 The title of my editorial does not need to be changed; what needs to be changed is the mindset and knowledge of practitioners who use AECs about how to achieve the optimally low risk-benefit ratio of AECs.

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References


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through these catheters, we recommended in our case report that jet ventilation through these catheters should not be necessary during the brief period of tube exchange.

According to the editorial of Benumof, air entry should not exceed air exit. The incidence of complicating barotrauma may be decreased by selecting a properly sized exchange catheter in proportion to the size of the endotracheal tube, by regulating the airway pressure to low levels, and by delivering oxygen jets of short duration followed by a long expiratory pause. Also, it is important to monitor chest inflation and chest deflation both. As suggested by Dr. Haridas, jet ventilation should be discontinued the moment there is incomplete chest deflation, and there should be a high index of suspicion regarding the development of tension pneumothorax.

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References

1. Baraka AS: Tension pneumothorax complicating jet ventilation via a Cook airway exchange catheter. Anesthesiology 1999; 91:557-8

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Another Use for Nasopharyngeal Airway

To the Editor—Dominguez described a simple method of monitoring end-tidal carbon dioxide in spontaneously breathing adults during deep sedation. He fashioned a nasopharyngeal airway connected to a 15-mm endotracheal tube connector. This apparatus was then connected to an anesthesia circuit in the usual fashion with side-stream carbon dioxide sampling at the elbow.

This same apparatus can also be used in children with ankyloglossia for frenectomy during general anesthesia. A 20-French nasopharyngeal airway (Rusch, Duluth, GA) is connected to a 15-mm endotracheal tube connector from a 5.5-mm endotracheal tube. This device allows spontaneous ventilation, relieves airway obstruction, and allows the surgeon to work uninterrupted, as opposed to administering intermittent mask ventilation.

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Reference


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In Reply—I thank Dr. McMillon for his comments regarding his experience using nasopharyngeal airways during general anesthesia for children undergoing frenectomy. An important consideration, however, is that when using nasopharyngeal airways to deliver anesthetic gases, excess gas will overflow through the mouth, escaping into the environment. Even though no firm evidence suggests that trace concentration of anesthetic agents present a health hazard, there is no definitive proof to the contrary. Therefore, the use of uncuffed supra-