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.

Anis Baraka, M.D., F.R.C.A.
Professor and Chairman
Department of Anesthesiology
American University of Beirut
Beirut, Lebanon

References

(Accepted for publication February 7, 2000.)

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.

C. Dale McMillon, M.D.
Assistant Professor

Director of Pediatric Anesthesia Education
Children's Medical Center
Medical College of Georgia
Augusta, Georgia 30912

Reference

(Accepted for publication February 11, 2000.)

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-