CORRESPONDENCE

Helen W. Karl, M.D.
Assistant Professor
Department of Anesthesiology
University of Washington and Children’s Hospital and Medical Center
4800 Sand Point Way NE
Seattle, Washington 98105

References


Proper Placement of the Esophageal Tracheal Combitube

To the Editor.—Green and Beger1 reported two cases in which malposition of the esophageal tracheal combitube (ETC) resulted in inability to ventilate a patient’s lungs. As alternatives to tracheal intubation, devices such as the ETC and the laryngeal mask airway are used more frequently in clinical practice. Thus, verifying the proper placement of these devices becomes a source of legitimate concern.

We evaluated the effectiveness of the self-inflating bulb (SIB) in identifying the location of the ETC and facilitating its proper positioning in anesthetized patients.2 In all patients studied, the SIB reliably identified either correct (4/5) or improper (1/5) positioning of the ETC. When the ETC is in proper position (fig. 1), a compressed SIB reinflates immediately when connected to the proximal lumen (which permits ventilation via pharyngeal perforations) and will remain compressed when connected to the distal lumen (which leads into the esophagus). In three patients, delayed reinflation (2–4 s) or absence of reinflation was noted when the compressed SIB was connected to the proximal lumen. This corresponded with the inability to ventilate adequately through either lumen. In these cases, slowly withdrawing the ETC 1–2 cm resulted in instantaneous reinflation of the SIB when retested, suggesting proper ETC positioning. Subsequent easy ventilation via the proximal lumen confirmed correct positioning. Based on our findings, we suggested a simple algorithm for use of the SIB to facilitate proper positioning of the ETC.2

The SIB has been shown to be a useful adjunct in differentiating between esophageal and tracheal intubation in anesthetized patients.3–5 Its usefulness in assisting the correct positioning of other airway devices shows promise as well. Preliminary investigations at our institution suggest the SIB also may facilitate proper positioning

Fig. 1. When properly positioned, a compressed self-inflating bulb instantaneously reinflates when connected to the proximal lumen by aspirating gas from the lungs via the perforations (arrows) and will remain compressed when connected to the distal lumen.

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of the laryngeal mask airway. Although using the SIB in no way precludes the appropriate clinical assessment of adequate ventilation, i.e., bilateral breath sounds, we believe the ability of the SIB to facilitate the proper positioning of the ETC warrants its use.

Yaser Wafai, M.D.
Edward A. Czinn, M.D.
Attending Anesthesiologists
Illinois Masonic Medical Center
836 West Wellington Avenue
Chicago, Illinois 60657

Clinical Assistant Professor of Anesthesiology
University of Illinois College of Medicine
Chicago, Illinois

M. Ramez Salem, M.D.
Chairman
Department of Anesthesiology
Illinois Masonic Medical Center
Clinical Professor of Anesthesiology
University of Illinois College of Medicine
Chicago, Illinois

Anis Baraka, M.D., F.R.C.Anaesth. (Hon)
Professor and Chairman
Department of Anesthesiology
American University Hospital
Beirut, Lebanon

References


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Ondansetron or Metoclopramide in Children Undergoing Tonsillectomy

To the Editor.—Furst and Rodarte recently reported that 0.15 mg/kg intravenous ondansetron is highly effective in reducing post-tonsillectomy vomiting in children and that droperidol and metoclopramide are not effective. These data are significant because droperidol and metoclopramide have been reported to be effective prophylactic antiemetics in children. However, contrary to the authors’ introductory statements that “no studies to date have examined the use of ondansetron in children for the prevention of postoperative emesis,” numerous clinical investigations and abstracts on this subject are published. In one of these reports, 0.15 mg/kg intravenous ondansetron is reported to decrease vomiting after tonsillectomy in children from 73% (of the placebo group) to 23% (of the ondansetron group).

In addition, we question a premise of their experimental design. Specifically, the authors state that the dose of metoclopramide used in their study (0.5 mg/kg intravenously) was “selected from the literature” and has been shown effective in preventing postoperative emesis in children at high risk for this complication. However, in none of the references to this claim has the use of this dose of metoclopramide been studied in healthy children undergoing surgery.

The authors attempt to further justify this relatively large dose of metoclopramide by stating that doses as large as 3 mg/kg intravenously are used for the prevention of chemotherapy-induced vomiting. The authors fail to mention that this dose of metoclopramide (3 mg/kg intravenously) was part of an antiemetic regimen that included 25–50 mg intravenous diphenhydramine, decadron, and lorazepam. In another article coauthored by Furst and Rodarte, they state a reluctance to use more than 0.25 mg/kg metoclopramide because of the potential for extrapyramidal side effects. Has the safety and efficacy of 0.5 mg/kg intravenous metoclopramide in children during the perioperative period been established? If not, were parents of subjects in this study apprised of the experimental nature of this dose of metoclopramide?

John B. Rose, M.D.
Thalia M. Martin, M.D.
Department of Anesthesiology
Alfred I. duPont Institute of the Nemours Foundation
1600 Rockland Road
P. O. Box 269
Wilmington, Delaware 19899

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