0.025-inch flexible guide wire was threaded retrograde through the needle and cords and brought out through the mouth. Multiple attempts were then made to pass first a 3.0 and then a 2.5 endotracheal tube over the wire into the larynx (blind initially, and then under direct vision with laryngoscopy); none of these attempts was successful. It appeared that the endotracheal tube was impinging on a laryngeal structure and was not stiff enough to pass into the trachea. Rotating the tube did not help.

A 2.5 endotracheal tube into which a stylette had been inserted was then, under direct vision, placed along the side of the guide wire that led directly to the larynx. The tube was successfully passed into the trachea on the second attempt. Breath sounds were confirmed; the wire was removed from the trachea; anesthesia was begun with halothane; and the surgery proceeded without complication. The child was taken to the neonatal intensive care unit postoperatively with the endotracheal tube in place, and the trachea was extubated the following day.

The options available for obtaining airway control in an infant with a difficult airway include awake intubation ("blind" or with direct visualization), fiberoptic laryngoscopy, retrograde techniques, and awake tracheostomy. In the case we describe, multiple unsuccessful attempts were made at awake intubation. Unfortunately, we did not have available to us a fiberoptic laryngoscope small enough for a 3.0–3.5 endotracheal tube (2.8 ID), so direct fiberoptic laryngoscopy and retrograde wire-assisted fiberoptic laryngoscopy were not possible. We placed a wire retrograde through the cricothyroid membrane but were not able to pass an endotracheal tube over the wire and through the cords. Benumof points out that in this instance the tube is generally impacted upon a vocal cord or the epiglottis and that 90° rotation may alleviate the problem. In our case, rotation of the tube over the wire did not help, and under direct vision we advanced a 2.5 endotracheal tube with a stylette along the course of the wire, which led to the glottic opening and facilitated oral tracheal intubation. We should point out, however, that this technique is not without risks. Cannulation of the trachea of an infant could conceivably lead to bleeding or airway injury. If a smaller wire is available (Arrow 0.018-inch) then a 22-G needle can be used to puncture the cricothyroid membrane.

This case demonstrates the usefulness of retrograde catheterization with direct vision for intubating the trachea of a very small infant. The inability to pass an endotracheal tube over a retrograde wire should not lead to total abandonment of the technique. If a small fiberoptic laryngoscope is not available, the wire may prove an invaluable guide to intubation by direct visualization.

DONALD SCHWARTZ, M.D.
Assistant Professor in Anesthesia
JAI SINGH, M.D.
Resident in Anesthesia

Department of Anesthesia
Tufts University School of Medicine and Baystate Medical Center
Springfield, Massachusetts 01199

REFERENCES


(Accepted for publication June 10, 1992.)

More on: Improving the Clinical Utility of Anesthetic Drug Pharmacokinetics

To the Editor—In a recent editorial, we recommended using computer simulations to interpret pharmacokinetic results. In response to requests from several investigators and clinicians, we have revised the software used to create the graphs shown in the editorial to make it user-friendly. The software will run on any MS-DOS computer and is available, at no charge, to all interested individuals.

STEVEN L. SHAFER, M.D.
Assistant Professor of Anesthesia
Stanford University School of Medicine
Anesthesiology Service (112A)

Veterans Administration Medical Center
3801 Miranda Avenue
Palo Alto, California 94304

REFERENCE


(Accepted for publication June 12, 1992.)