A Complication of Fiberoptic Nasal Tracheal Intubation

To the Editor—The complication reported by Nichols and Zornow is similar to an earlier report of three cases wherein the fiberscope was mistakenly introduced through the Murphy’s eye, resulting in inability to withdraw the instrument after successful nasotracheal intubation.

Since that time we have observed that the longitudinal radio-opaque marker leading to the terminal opening on every endotracheal tube was clearly visible through the fiberscope. We reiterate our recommendation never to pass the fiberscope blindly but always under direct vision identifying both the terminal opening and the Murphy’s eye. When in doubt, the radio-opaque marker mentioned above should help to differentiate between these two openings.

It is true that this problem can be avoided totally by loading the endotracheal tube on to the fiberscope before insertion. It is not always easy to judge the size of the nasal passage when the fiberscope is passed first. A 4–6 mm fiberscope may pass easily while a 7.0 mm or a 7.5 mm ID tube, which has an external diameter of 9 mm and 10 mm respectively, may not pass, or if passed, may be pinched (compressed) by a bony spur or a narrow nasal passage. Advancing the endotracheal tube over the fiberscope in this situation could be difficult, traumatic, and/or impossible. Passing the endotracheal tube prior to the fiberscope will help to recognize these anatomic factors by the distortion produced in the normal contour of the endotracheal tube as seen with the fiberscope. If no distortion in the endotracheal tube contour is seen and the fiberscope passes with ease through the nasally passed endotracheal tube, then that tube should advance into the trachea over the fiberscope with minimal difficulty and trauma.

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REFERENCES


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