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In Reply:—While it is true that the continuous epidural infusion of
opiates may avoid some of the side effects associated with bolus epidural
administration, as used in our study, the former technique requires
the continuous presence of or availability of skilled nursing care. The
newer modalities of postoperative analgesia should be available to all
patients and not necessarily those requiring an intensive care setting.
The purpose of the study was not to downplay the role of epidural
opiates but to compare these different forms of postoperative analgesia
out of the ICU setting on healthy patients who, after all, constitute the
majority of patients undergoing elective surgery. In such patients, the
same degree of specialized nursing is not necessarily available and an-
algesic efficacy, together with simplicity of technique, need to be bal-
anced against patient safety and nursing acceptance.

In this setting, both Eisenach et al.1 and our group2 found patient
satisfaction to be an important consideration when comparing these
techniques. Dr. Hord should not make the mistake of overinterpreting
our conclusions to reflect the needs of critically ill patients, but to
represent the application of these newer approaches to analgesia out
of the ICU in a very different patient population.

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Blind Nasal Intubation of an Anpeic Neonate

To the Editor:—The recent correspondence from Gouverneur1
prompts me to describe another approach to tracheal intubation of
infants.

I was asked to assist in the intubation of the trachea in a 7-week-
old, 2-kg infant having severe apneic episodes. A diagnosis of trisomy
13 (Patau Syndrome) had been made, but this was not known by the
staff involved in resuscitation. Micropenis was obvious and laryn-
goscopy revealed only the proximal epiglottis but not the glottis.

A pediatric malleable metal stylet was employed to curve the 2.5-
nm ID Portex endotracheal tube into a suitable shape and, while ob-
serving the anterior neck, blind nasal tracheal intubation was successful
at the first attempt.

Other reported approaches to overcoming difficult tracheal intu-
bation in neonates include conventional blind nasal tracheal intuba-
tion,1 blind nasal tracheal intubation with the patient in the prone position,2
anterior commissure laryngoscope with optical stylet,3 nasopharyngeal
intubation,4 tracheoscopy,5 and fiberoptic endoscopy.6 Although Berry6
has stated the age range for using the stylet in blind nasotracheal in-
tubation to be "from three years through adult," I have since 1981
used the technique in 14 younger patients, including five infants of
2.9-4.3 kg body weight (two were stillborn).

The small size endotracheal tubes are rather soft and floppy and
very little "feel," necessary for blind tracheal intubation, is transmitted
up the tube. In addition, they do not, in contrast to adult sizes, maintain
a suitable distal curve. Therefore, a lubricated malleable metal stylet
(fig. 1) is used to provide the latter, but without protruding from the
end of the tube. It also enables the tube to be manipulated in a way
not possible without it. I shape the tube roughly to a right angle with
the limbs approximating the respective lengths of nasal passage and
pharynx. Subsequent adjustments to the curvature, i.e., more obtuse
or acute, and distal limb length are made in the light of experience at
each attempt until tracheal intubation is obtained. To locate the glottis,
either the breath sounds, preferable in the young, or the external
visual signs described by Jacoby7 and Bennett et al.8 may be used.

In contrast to Berry, I have not found it necessary when using the
stylet, for any age of patient, to have "a short sharper angle at the tip."
8 The anterior angulation required to enter the larynx can be
obtained by manipulation of the stylet supported tube.

The same method can be similarly applied when blind oral tracheal
intubation is indicated.

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