Mechanical Aids for Fiberoptic Endoscopy

Successful endoscopic intubation depends upon the ability to identify anatomical landmarks. Considerable experience can be gained in non-intubated patients ventilated by mask or oropharyngeal or nasopharyngeal airways. The mechanical aids illustrated permit endoscopy in anesthetized patients with minimal interference with ventilation.

Addition of an endoscopic port to a conventional face mask permits fiberoptic endoscopy by the nasal (fig. 1) or oral (fig. 2) route in spontaneously ventilating patients. Use of a potent inhalation anesthetic agent may be continued during intubation, thus prolonging the time available for intubation.

An oral airway with a central groove for passage of the endoscope is useful in anesthetized or sedated patients (fig. 2). The airway prevents the tongue from falling backward and the patient from biting the endoscope. The central groove guides the endoscope in the midline. The airway can be removed without disturbing the position of the endoscope. A slit at the end of the airway allows advancement of the tip of the endoscope beyond the epiglottis.

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**Fig. 1.** Mask with endoscopic port.

**Fig. 2.** Oral airway with central groove for passage of endoscope and side ports for suction catheter.

**Fig. 3.** Oral airway with Rowbotham connector and corrugated tubing.

**Fig. 4.** Binasal airway.
glottis to visualize the larynx. Side channels are provided to permit suctioning without interruption of endoscopy. Topical anesthesia facilitates this technique.

An oral airway fitted with a Rowbotham connector and a short length of corrugated tubing is ideal for administering inhalation anesthesia during nasotracheal endoscopy and intubation (fig. 3). The suction port facilitates removal of secretions without interruption of endoscopy or ventilation.

Binasal airways may be used for ventilation during oral endoscopic intubation (fig. 4). The grooved oral airway may be used simultaneously to facilitate endoscopy.

These mechanical aids are well tolerated by patients, minimize trauma, facilitate intubation, and allow more time during fiberoptic endoscopy without compromising ventilation.

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Oxytocic Drugs Have Different Cardiovascular Effects

To the Editor:—In the paper of Datta et al. 1 about nausea and hypotension during spinal anesthesia for cesarean section, there is a phrase that may be misleading. They say that prophylactic ephedrine “may result in postpartum hypertension because of synergism with oxytocic (sic) drugs.”

Oxytocic (not oxytotic) drugs are those drugs affecting uterine motility. Clinically the oxytocic drugs used are oxytocin and ergot alkaloids and these have opposite cardiovascular effects. All of the natural alkaloids of the ergot cause a significant increase in blood pressure as a result of direct peripheral vasoconstriction. 2 Sudden hypertension produced by ergot may be associated with coronary vasoconstriction, leading to myocardial ischemia, acute heart failure, and acute pulmonary edema. 3

Oxytocin by contrast causes vasodilation of both alpha and beta-adrenoreceptive vessels. The vasodilating effect of oxytocin causes transient hypotension, the degree and duration of which are related to the dose of the drug and the rate of injection. 3 The amounts of oxytocin administered for most obstetric purposes are insufficient to produce marked alterations of blood pressure. However, when very large doses are administered for therapeutic abortion or during uterine surgery, a marked fall in arterial pressure may occur. 2

Based upon the cardiovascular effects of these drugs, can we expect hypertension because of synergism between oxytocic drugs and ephedrine? I believe the correct statement is “this (prophylactic) use of ephedrine may result in postpartum hypertension because of synergism with ergot alkaloids.” This is true 4, 5 and not misleading.

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REFERENCES

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