patients aspirated during endotracheal tube change with sedation and paralysis under direct vision and a second became hypotensive during the procedure. Only one of the bronchoscopic tube change patients became hypotensive.

The availability of smaller diameter bronchoscopes like the Olympus BF-4B2® (4.8 mm, OD) and the BF-3C4® (3.5 mm, OD) has allowed the use of this technique for patients with smaller laryngeal dimensions via smaller internal diameter endotracheal tubes. There is no reason why any skilled endoscopist cannot perform this procedure; however, I should like to emphasize my concern that the technique should only be attempted with the back-up of proven alternatives like direct laryngoscopy and intubation or emergency tracheostomy by skilled individuals in the event of unexpected difficulty.

In conclusion, I should like to endorse the technique described and agree that it may be safer and more certain than other methods commonly used.

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Use of Cold Nasogastric Tubes Corrects Problems Due to Pliability

To the Editor—The recent Clinical Report by Rosenbaum et al.1 cites excessive pliability of nasogastric tubes as the major reason for difficulties in changing endotracheal tubes. The authors note that the flexible fiberoptic bronchoscope provides a more rigid stent over which to pass the endotracheal tube.

We have not encountered the authors' difficulties using nasogastric tubes for endotracheal tube change, perhaps because we have, on occasion, used a Levin tube made more rigid by exposure to cold. Our procedure consists of placing a nasogastric tube, still sterile inside its wrapper, in a container of ice for 20 min. This makes the Levin tube less pliable to guide the new endotracheal tube into the trachea. The nasogastric tube and new endotracheal tube are lubricated to facilitate easier passage.

Admittedly, use of the flexible fiberoptic bronchoscope provides the greatest number of options for changing endotracheal tubes since a nasal tube can be changed from one nostril to the other or converted to an oral tube. (Use of a nasogastric tube, on the other hand, for the most part requires that the existing route be used for the new endotracheal tube.) However, in a situation where a fiberoptic bronchoscope, or personnel trained in its use are not available, or when the endotracheal tube is too small to allow passage of the fiberoptic bronchoscope, a cold-hardened Levin tube may provide a successful solution to the clinical problem. Finally, if difficulties should occur during the endotracheal tube changeover, the lumen of Levin tube may be used to administer oxygen until successful passage of the new endotracheal tube can be accomplished.

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