radiopaque catheter. The sealed end of the plastic sheath is cut off and the sheath passed along the catheter. The pulmonary-artery catheter is then passed into the jugular vein and into the pulmonary artery in the usual fashion. After a satisfactory placement is reached, the cut end of the Intracath sheath is passed over the hub of the introducer. A sterile ligature is used to hold the plastic sheath in place around the catheter after fully extending the sheath (fig. 1).

Cultures taken at 24 and 48 hours from the interior of the sheath 1 and 3 cm above the hemostasis valve of the introducer in ten successive patients failed to show growth of aerobic and anaerobic bacteria.

COMMENT

Approximately 25 cm of catheter remain sterile, allowing the catheter to be moved easily to a wedge position after dislodgement or migration.

Uvular Edema, a Rare Complication of Endotracheal Intubation

R. RAVINDRAN, M.D.,* and S. PRIDDY, M.D.†

Many complications resulting from endotracheal intubation have been reported. Recently we had a patient in whom marked edema of the uvula developed following endotracheal intubation.

REPORT OF A CASE

A 22-year-old primigravida of 38 weeks’ gestation was admitted to the hospital for observation because of severe pre-eclampsia. Blood pressure was 160/105 mm Hg. The patient was not allergic to any medication. Bed rest and administration of diuretics were instituted. The patient did well for a week after which she complained of severe headache, and the blood pressure was found to be 180/110 mm Hg. She was taken to the obstetric intensive care unit, hydralazine, 10 mg, iv, administered, and blood pressure was closely monitored. The blood pressure remained elevated after several doses of hydralazine. An oxytocin challenge test was positive. Amniocentesis was done with the idea of obtaining a lecithin– sphingomyelin ratio. Blood was obtained from the tap and was found to be positive on APT test. The patient was taken to the operating room for emergency cesarean section.

The patient was preoxygenated with 6 mg d-tubocurarine and O₂ for 3 min. She then underwent rapid-sequence intubation with thiopental, 200 mg, and succinylcholine, 120 mg. A 7.5-mm Shiley high-volume low-pressure cuffed ethylene oxide-sterilized endotracheal tube was placed without difficulty. The tube was secured with an adhesive tape. Anesthesia was maintained with N₂O and O₂ before delivery and narcotic, N₂O, and O₂ after delivery. The procedure lasted an hour and 40 minutes. The trachea was extubated in good condition at the end of anesthesia. No undue amount of coughing on the tube had occurred.

Twenty-four hours later the patient complained of difficulty in breathing. It has been gradual in onset. Examination revealed obstructed nasal passages secondary to nasal congestion and incidental epistaxis. Oral examination revealed a grossly edematous uvula (golf-ball size). Cyanosis was not seen. O₂ was administered by mask. Diphenhydramine, 50 mg, was given orally and dexa-methasone, 8 mg was injected iv. Improvement in breathing was seen in 30 minutes. Six hours later the uvula was of normal size. The patient needed no further steroid treatment and recovery was uneventful.

DISCUSSION

In our review of literature we could not find any report of uvular edema resulting from endotracheal intubation. It has been reported as an allergic reaction to administration of scopolamine® and atropine. This patient did not receive either of these drugs. Normally, in the intubation position the uvula falls away from the hard palate. In this case it might have folded back on itself and been entrapped between the endotracheal tube and hard palate.

REFERENCE


* Assistant Professor.
† Senior Resident.

Received from the Department of Anesthesiology, Indiana University Medical Center Indianapolis, Indiana 46202. Accepted for publication November 9, 1977.

Address reprint requests to Dr. Ravindran.

003-5022/78/0500—0374 $0.50 © The American Society of Anesthesiologists, Inc.