Two additional connections must be made to fit the water trap into the circuit. Using our "specimen trap" the connections are snug. If different "specimen traps" at other institutions are used, care must be taken to ensure that accidental disconnections do not occur.

Depending on the chosen FGF rate and temperature setting of the heating source, condensation in the inner tube may still occur. However, it is less than without the water trap.

We did not measure the effect of the "specimen trap" on the humidity of the circuit. However, with the usual FGF rate used in the Bain or CPRAM circuits, the effect should be negligible.

We have found this system to provide a simple and effective means to both protect the patient and collect excess condensed water.

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Preventing kinking of disposable preformed endotracheal tubes

To the Editor:

The use of preformed endotracheal tubes, such as the RAE preformed tube (Mallinckrodt)¹ or Child's Anatomical tube (Portex)² reduces the likelihood of kinking occurring after insertion of the tube.² However, we have frequently experienced episodes of kinking outside the mouth, at the connector site, when using smaller sizes of these disposable preformed tubes. The tubes can be protected from kinking simply by covering them with a short piece of a used endotracheal tube of appropriate size, from the connector site to the angled portion. We feel that

addition of this simple covering improves the safety of preformed disposable endotracheal tubes.

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Clinical signs of difficult direct laryngoscopy*

To the Editor:

We read with interest the article by Mallampati *et al.*,¹ in which the authors showed that a grading system evaluating the ease in visualizing the faucial pillars, soft palate, and uvula might predict the ease of direct laryngoscopy and tracheal intubation under general anaesthesia. Patients in whom these structures could be easily seen were ones in whom the glottis could be easily exposed and the trachea intubated. We have recently anaesthetized two patients in whom all three posterior pharyngeal structures could be easily visualized (Figure 1) but in whom the glottis, including corniculate cartilages, could not be seen by multiple anaesthetists using different blades for direct laryngoscopy.

A 3-mg dose of tubocurarine IV and repeated doses of succinylcholine IV were administered to both patients so as to eliminate twitch of the thenar eminence during stimulation of the ulnar nerve at the wrist. The head and neck of both patients were adjusted to provide what was felt to be an optimal alignment of the axes of mouth, pharynx, and larynx. One patient was intubated despite inadequate exposure. The other patient was awakened and subsequently intubated at a later date using fiberoptic laryngoscopy. Mobility of the cervical spine and temporomandibular joint was unrestricted in both patients. Indirect laryngoscopy by our ENT service showed no abnormality in either patient. However, the distance from thyroid cartilage to tip of the mandible (Figure 2) was found to be less than 6.0 cm in both cases, using the method

*The opinions contained herein are those of the authors and may not reflect those of the Department of the Army or Department of Defense.