FIGURE 2 Fogarty catheter in place.

again inflated. Ventilation of the right lung ceased and pneumonectomy was easily performed. The patient was extubated postoperatively and made an uneventful recovery.

Several points are emphasized:

- 1 Use of the adaptor allowed passage of the Fogarty catheter through the endotracheal tube. After removal of the bronchoscope, an adequate seal was maintained by closing the cap.
- 2 Tape was used to secure the Fogarty catheter to the endotracheal tube adaptor to prevent movement within the tracheo-bronchial tree. The bronchoscope should always be available so that suspected displacement of the blocker may be readily investigated.
- 3 Use of a single lumen tube in the "difficult" intubation may be preferable if postoperative mechanical ventilation is anticipated.
- 4 Careful preoperative examination will minimize the number of airway "surprises" which are notorious for adding grey hair to the heads of anaesthetists.

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Treatment of persistent penile erections during urological procedures

To the Editor:

A serious although infrequent inconvenience to urologists is the persistent penile erection of a male patient, that renders impossible some procedures, such as cystoscopy. Many standard anaesthesia¹⁻⁵ and urology⁶⁻¹¹ texts are unhelpful, although Bodner¹² offers the following suggestions; ice-packs, ganglion blockade and muscle relaxants (tubocurarine), added barbiturate or depth of general anaesthesia, methocarbamol, and metaxalone, noting that none are reliable and that all may be inconvenient or hazardous. References to the problem are sparse, Benzon *et al.*¹³ review the use of ketamine (noting failures) and mention the use of methoxamine and phenylephrine. I have heard a host of other suggestions: alpha, beta, ganglion and muscarinic blockade (or agonism!), administration of methantheline bromide, narcotics, benzodiazepins, butyrophenones or phenothiazines in conjunction with and as premedication for anaesthesia, the use of sub-arachnoid or extra-dural regional block and substitution between inhalational anaesthetics. All of these manoeuvres are either time-consuming, unreliable, or have undesirable additional effects and in desperation, a surgeon may even resort to perineal urethrotomy.¹³ There is a simple alternative, used I am sure by others, but unpublished as far as I am aware, that may be worthy of wider recognition.

Blockade of the dorsal nerves¹⁴ of the offending organ, with any handy vasoconstrictor-free local anaesthetic (e.g., one per cent lidocaine), is quick and easy to perform and on five occasions I have found it to be rapidly efficacious. A modest flaccid engorgement still remained after a few minutes, but was not bothersome. Four of these patients were under otherwise satisfactory inhalational general anaesthesia while one was paraplegic and awake.

The physiology of penile erection has been reviewed by Comarr¹⁵ and by Weiss.¹⁶ It is a complex interaction of sympathetic, parasympathetic and supratentorial efferents via several paths which is responsible for the initiation and the maintenance of the phenomenon. I would speculate that dorsal nerve block interrupts the afferent limb of a terminal facilitatory feed-back arc that sustains erection and that the technique might fail if overwhelmed by the other influences.

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Percutaneous transtracheal ventilation for laser endoscopic procedures in infants and small children

To the Editor:

I believe that the method suggested by Ravussin and his colleagues in their recent article¹ may be extremely hazardous.

I cannot accept that on the basis of a report of only two cases a technique can be labelled as "... safe and useful ...". Some years ago Dr Fearon and I drew attention to the dangers of intratracheal catheter jet ventilation in children with obstructive airway lesions.² Since that time I have been made aware of further deaths resulting from the use of this method. To these dangers the present authors have

added those of percutaneous tracheal puncture. They are also advocating the use of a jet distal to a major obstruction lesion, a practice which is generally thought to be contraindicated.³ True they have added the use of an "exit route" for insufflated gases, and they stress vigilance and "fail safe" systems to minimise the risk of barotrauma. I am concerned, however, that such precautions are not infallible and that their method introduces some unnecessary potential dangers when much safer and simpler alternative methods and anaesthesia are available.

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REPLY

We appreciate Dr Steward's comments on our recent article, and agree with his concern about the possible complications using percutaneous transtracheal jet ventilation. However, we believe that adequate precautions were undertaken to minimise these risks, and that there is a significant added advantage in avoiding tracheostomy in small children. Furthermore, a catheter introduced into the trachea under endoscopic control allows at any time simple insufflation of oxygen ($1-3 \text{ L} \cdot \text{min}^{-1}$) should complete obstruction occur. We wish to emphasise that we do not suggest this technique for routine cases where the use of a more conventional anaesthetic technique is possible, but that it should be reserved for use in specific cases such as described. Laser surgery, unlike endoscopy, requires good surgical access to an immobile operative site, usually achieved with the aid of muscle relaxation. However, the importance of an "exit route" for the insufflated gases can not be over-emphasised,¹⁻³ and a bronchoscope in place is a perfect guarantee. Thus in certain rare cases we have found the technique we described to be a valid alternative in experienced hands. We would be interested to know the "safer and simpler alternative methods of anaesthesia" that Dr Steward would have used in the cases reported, in particular case I, the 4-month-old infant with a 25 mm long subglottic haemangioma obstructing the tracheal lumen by approximately 80 per cent while at the same ensuring surgical access to an immobile operating field.

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