REFERENCES

- 1 Berner MS. See Ref. 1, p. 438 for title. Can J. Anaesth 1987; 34: 622-6.
- 2 Comm G, Rendell-Baker L. Back pressure check valves a hazard. Anesthesiology 1982; 56: 327-8.

REPLY

Dr. Dodgson addresses an extremely important issue that I omitted from my discussion. He stresses the necessity of testing separately for leaks in the anaesthetic machine (as opposed to the breathing circuit) by pressurizing the anaesthetic system using normal or low flows. This argument is well taken. I would however point out that it is also important to verify independently the integrity of the oxygen flush bypass circuit.

As in Dr. Davies' report, the disconnection we experienced also occurred shortly after anaesthetic machine maintenance. His protocol for preventive measures merits careful attention. Both Drs. Dodgson and Davies describe the problem that the hanging bellows on anaesthetic ventilators do not collapse in the face of major leaks.

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General anaesthetic management for laser resection of central airway lesions

To the Editor:

We read with interest the article by Perera and Mallon¹ on the general anaesthetic management for laser resection of central airway lesions. They cite the use of Nd:YAG laser in this type of surgery and include pulse oximetry in the monitoring of their patients.

Eye protection for personnel in the operating room during Nd:YAG resection requires the wearing of goggles. These goggles completely surround the orbital margins and the patient is viewed through a coloured filter. We have noted that this filter impairs the visual assessment of a patient's colour, making pulse oximetry essential. It also hinders the ability to appreciate both digital and trend displays on the oximeter and other monitors. The degree of interference varies with different filter colours and monitors.

We caution anaesthetists prior to the purchase of protective goggles for this application to verify that the ability to read monitor displays is not adversely affected.

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REFERENCE

- 1 Perera ER, Mallon JS. General anaesthetic management for laser resection of central airway lesions in 85 procedures. Can J Anaesth 1987; 34: 383-7.

Fracture of a RAE endotracheal tube connector

To the Editor:

We recently experienced an unusual problem caused by the fracture of a RAE oral endotracheal tube connector. We were anaesthetizing an infant for a major craniofacial reconstruction. The patient was paralyzed and ventilated using a 4.0 uncuffed oral RAE endotracheal tube (Mallinckrodt, Glen Falls, NY). The tube was in a satisfactory position and secured to a tooth using a wire suture.

During the course of the procedure secretions accumulated and it became necessary to suction the endotracheal tube. It was difficult to disconnect the metal collar of the CO₂ analyzer from the 15 mm connector of the endotracheal tube with one hand, while holding the tube securely with the other hand and working under the drapes.

The breathing circuit suddenly came free from the endotracheal tube by breaking at the neck of the 15 mm connector, leaving the larger part connected to the breathing circuit and the smaller part stuck in the endotracheal tube. It would have been difficult to replace the endotracheal tube rapidly with the old tube stitched in position. Mouth to tube ventilation might have been possible as a temporary expedient. In a previous similar case involving a 4.0 Portex connector, apposition of the broken ends enabled ventilation to continue pending reintubation.¹ Fortunately the connector of a 3.5 Portex endotracheal tube was at hand and this could be fitted into the stub of the old connector, which remained stuck in the RAE endotracheal tube (see Figure). A cable tie ("Panty," Panduit Corp., Tinley Park, IL) was used to provide additional security. The CO₂ analyzer was temporarily removed and ventilation of the patient resumed.