Correspondence

Intubating conditions

To the Editor:

During a rapid sequence induction, "Cricoid pressure," (the Sellick Manoeuvre) is used to prevent, or at least delay, regurgitation from the stomach to the pharynx. When a mildly difficult intubation occurs, an assistant may be asked to move the upper trachea or the thyroid cartilage either posteriorly or laterally to improve visualisation of the larynx. Drs. Bruin and Buckley appear to equate the two quite different anatomical manipulations by referring to them both as "Cricoid pressure." This, I feel, only causes confusion in the minds of those nurses and technicians who assist us during induction.

J.D. (Ian) St. Clair FFARCS
Edmonton, Alberta

REPLY

We thank Dr. St. Clair for his response. The intent of our letter was to explain a mechanism by which well intentioned "Cricoid pressure" applied when the head is not in an incubating position, can interfere with, rather than facilitate, intubation during rapid sequence induction (RSI).

Because the cricoid cartilage is in intimate contact with both the proximal trachea and thyroid cartilage, pressure on it can be used to manipulate the larynx into view during both RSI and difficult incubation. In order to improve visualisation during RSI the "cricoid" pressure should be applied while the head is maintained in the "sniffing" position. If it is not, skin tension and pressure can cause the head to be fixed in flexion. Pressure may then need to be released and reapplied to improve visualisation, a move which could increase the risk of aspiration. By comparing the application and purpose of laryngeal pressure during RSI with that applied during difficult incubation assistants will be better able to help.

Norm Buckley MD FRCPC
Gerard Bruin MD FRCPC
Hamilton, Ontario

Oesophageal aortic echo-Doppler and TEE

To the Editor:

We read with interest the report by Gueugniaud *et al.* on continuous oesophageal echo-Doppler measurement of aortic blood flow. We wish to point out that, contrary

to the author's claims, transoesophageal echocardiography (TEE) is readily available not only for infants but also for neonates. Paediatric biplane probes have been available since at least 1994 in North America and before that paediatric monoplane probes were used in neonates and infants. At Montréal Children's Hospital, we use biplane probes in neonates as small as 2.2 kg. The TEE is not only used for cardiac procedures but also for neurosurgical and orthopaedic procedures or whenever additional cardiac monitoring is required for a patient. As paediatric TEE is now widely used, it would be of interest to compare it with the oesophageal device for both reliability and cost-benefit.

Josée Lavoie MD
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REFERENCE

- 1 Gueugniaud P-Y, Muchada R, Moussa M, Haro D, Petit P. Continuous oesophageal aortic blood flow echo-Doppler measurement during general anaesthesia in infants. *Can J Anaesth* 1997; 44: 745-50.

REPLY

We appreciate Dr Lavoie's interest in our article.¹ The letter raises important precisions concerning the use of transoesophageal echocardiography (TEE) in infants and in neonates. In Canadian paediatric hospitals, paediatric TEE with *trained* operators seems to be now widely available for infants and for neonates whatever the surgical procedures. Unfortunately, it is not the case everywhere, even in some university hospitals in France.

This issue emphasises the interest of the echo-Doppler aortic blood flow (ABF) device. However, it remains a subordinate reason for we agree that this new oesophageal echo-Doppler device could not take the place of TEE. The data provided by echocardiography allow a diagnosis of a cardiovascular status at a given moment during the perioperative period: they are accurate and irreplaceable for a momentary assessment, but discontinuous. In contrast, the ABF echo-Doppler device is a monitor which, by integrating an haemodynamic profile, exhibits trends of the cardiovascular changes. This additional cardiac *monitoring* is an easy and completely operator-independent way to monitor *continuously* the haemodynamic variations during (paediatric) anaesthesia. As the findings on