An unusual cause of elevated airway pressures

To the Editor:

A two-week-old male infant in the NICU with bowel obstruction underwent urgent laparotomy. The patient was preoxygenated and premedicated with 0.02 mg atropine *iv*. Vital signs were normal (SpO₂ 100%, HR 145 bpm, BP 80/55 mmHg). Rapid sequence induction of anaesthesia and tracheal intubation were achieved with 10 mg propofol, 4 mg succinylcholine, and a 3.5 mm oral endotracheal tube (ETT) with a malleable stylet.

After intubation, the patient rapidly desaturated (SpO₂ 20%) and became bradycardic (HR 110 bpm) without hypotension. Breath sounds were equal in both lungs and absent over the epigastrium. Diffuse inspiratory wheezes were heard. Peak airway pressure was 30 cmH₂O. We decided to reintubate the trachea. As we prepared to remove the initial ETT, the nurse noticed that the stylet's plastic sheath was missing at its distal tip (see Figure 1). Removal of the anaesthetic circuit Y-connector revealed the missing piece lodged at the circuit end of the ETT. The SpO₂ returned to 100%, peak airway pressure decreased to 15 cm H₂O, and HR increased to 150 bpm with removal of the obstruction. The remainder of the anaesthetic course was uncomplicated.

The defect in the single-use stylet was located at a bend introduced into the stylet from multiple previous uses. This case, in which single-use equipment was re-used, illustrates the potential danger when economic considerations override safety issues.

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FIGURE 1 Endotracheal tube with obstruction from plastic sheath detached from flexible intubating stylet.

Decision-making in anaesthesia: an imbroglia of science, anecdotes and art?

To the Editor:

The recent editorial¹ touches on a very relevant issue facing the profession – the battle between science and art. Clinical decisions should be based on science rather than being validated as an “art” based on anecdotal experiences or the exigencies of cost control. The “artists” claim that a cocktail of propofol and thiopentone is as good as the former alone, and cheaper without a clear demonstration of the bio-equivalence of such cocktails with the pure but more expensive new agents.^{2,3} The latest textbook in ambulatory anaesthesia⁴ even legitimises artistic practices with endearing terms such as “the propofol sandwich,” without any supporting evidence.⁵ Recently, the same logic has been used to mix-and-match with alarming ingenuity, newer volatile agents with the older ones in spite of evidence to the contrary.⁶ Such practices are “culinary” at best and “pharmacological promiscuity” at worst, and need to be discouraged.

The art of inhalation induction was rendered virtually obsolete in most adults and older children with the availability of intravenous induction agents and their ability to rapidly telescope the planes of anaesthesia. Desflurane permits a similar rapid telescoping of recovery within minutes, thereby rendering obsolete the art of emergence from anaesthesia as required with older agents. Faced with such scientific advances, why should we practice old fashioned art?

Until the profession demonstrates its commitment to evidence-based medicine there is a substantial risk that the specialty may be viewed as soft on science and audacious on art and anecdotes.⁷

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