References

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- 2 Dorsh JA, Dorsh SE. The anesthesia machine. In: Retford DC (Ed.). *Understanding Anesthesia Equipment*, 3rd ed. Baltimore: William & Wilkins, 1994: 51–90.

The intubating laryngeal mask airway in severe ankylosing spondylitis

To the Editor:

I would like to congratulate Dr. Lu *et al.* for their article “The intubating laryngeal mask airway in severe ankylosing spondylitis”.¹ The article contributes to the growing wealth of information regarding the applicability of the intubating laryngeal mask airway (ILM) in patients with difficult airways by direct laryngoscopy. There is, however, a small mistake in their discussion. They stated that “to our knowledge, this is the first report of ILM insertion following sevoflurane induction.” Sevoflurane induction for insertion of ILM has been performed in many patients, both with and without difficult airways.^{2,3} The first report was back in March of 1998. This example goes to show that good ideas and sound planning are bound to be repeated.

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References

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- 2 Joo H, Rose K. Fastrach—a new intubating laryngeal mask airway: successful use in patients with difficult airways. *Can J Anaesth* 1998; 45: 253–6.
- 3 Joo HS, Rose DK. The intubating laryngeal mask airway with and without fiberoptic guidance. *Anesth Analg* 1999; 88: 662–6.

A normal capnogram despite esophageal intubation

To the Editor:

The authors reported normal capnograms despite esophageal intubation in a spontaneously breathing patient, who had a difficult intubation.¹ Given the sequence of events, experience suggests that a different scenario is more likely.

When the authors attempted a blind intubation, the tip of the tube could have been at or over the glottis, thereby producing normal CO₂ waveforms as well as normal end-tidal PCO₂ values during spontaneous ventilation. An armoured endotracheal tube can coil in the pharynx easily. On inflation of the endotracheal tube cuff, however, the tip of the tube dislodged out of the area above the glottis into the esophagus. This is consistent with the dramatic reduction in the end-tidal PCO₂ to values below 10 mmHg from the initial values of 38–40 mmHg. Furthermore, passing even the smallest fiberoptic bronchoscope through a 6.0-mm endotracheal tube requires considerable force which could have uncoiled the endotracheal tube, thereby, pushing the distal tip further along into the esophagus.

In absence of the following confirmatory tests, the hypothesis that the esophageal intubation produces normal CO₂ waveforms may not be valid. The initial position of the endotracheal tube tip, before inflation of the cuff when CO₂ waveforms were normal in shape and values, should have been confirmed via fiberoptic bronchoscope. Second, reproducing normal CO₂ waveforms with normal end-tidal PCO₂ values each time the cuff was deflated following inflation would strengthen the author's hypothesis that the endotracheal tube was indeed all along in the esophagus.

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Matthew Posner MD FRCP
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Reference

- 1 Asai T, Shingu K. Case report: a normal capnogram despite esophageal intubation. *Can J Anesth* 2001; 48: 1025–8.

REPLY:

I am aware of the possibility of an endotracheal tube being coiled in the pharynx (as cited such a report¹ in my article),² but would like to refute Drs. Shankar and Posner's claims.

They claim that passing even the smallest fibrescope through a 6.0 mm endotracheal tube requires considerable force. I^{3,4} (as well as others)⁵ have used a fibrescope (diameter: 3.5 or 4.0 mm) and a reinforced endotracheal tube (internal diameter: 6.0 mm) in several studies and have never experienced such a difficulty.

They also suggest that insertion of a fibrescope could have uncoiled the endotracheal tube and pushed the tube tip further along into the esophagus. In the case presented,² I could clearly see the distal aperture of the endotracheal tube even when the tip of the fibrescope was 5–6 cm proximal to the