FIGURE

Problems with CO₂ monitoring in a Siemens Kion anesthesia machine

To the Editor:

On three separate occasions I have noted a problem with CO₂ monitoring while using a Siemens Kion anesthesia machine. Each time the CO₂ monitor showed a decline in the end-tidal CO₂, and a flattening of the CO₂ curve, until the end-tidal CO₂ was zero. Checks showed that the patient remained ade-

quately ventilated and in stable condition throughout each episode.

Scrutiny of the CO₂ sampling tube revealed that in each case it was partly or completely broken at the site where it joins the water trap on the anesthesia machine. At this location it is near a drawer and can either get trapped in the drawer or pulled if it gets caught on the corner of the drawer as it opens (Figure).

The machine should be redesigned to reinforce the sampling tube or move it to a less vulnerable location. Until then, users are warned of this problem so that they can recognize it more quickly.

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Relationship between body mass index and ventilation with the Laryngeal Tube® in 228 anesthetized paralyzed patients: a pilot study

To the Editor:

The Laryngeal Tube® (LT; VBM, Medizintechnik, GmbH, Sulz, Germany) is a novel airway device consisting of a silicone airway tube and two cuffs. Once inserted, the proximal cuff lies in the hypopharynx and the distal cuff in the upper esophagus (Figure). We conducted a pilot study to assess the efficacy of the LT¹⁻³ throughout the surgical procedure and to determine whether the ability to obtain an effective airway with the LT is affected by the body mass index (BMI) of patients.

After obtaining Institutional approval and written informed consent, 228 patients ASA I/II, aged 18–65 yr, scheduled for elective urological surgery, were consecutively enrolled. Patients affected by gastroesophageal reflux, obesity, and hiatus hernia were excluded. Routine monitors were applied. The procedure was performed by five anesthesiologists experienced in the use of the LT. After preoxygenation for three minutes, anesthesia with myoresolution was induced.

Patients were divided in three groups, based on BMI: 1 < 20 kg·m⁻², 2 = 20–24.9 kg·m⁻², and 3 = 25–30 kg·m⁻². The LT size was chosen according to patient height: size 3 (< 155 cm), size 4 (155–180 cm), size 5 (> 180 cm). The LT was inserted with the head in the sniffing position. Cuffs were inflated to a pressure of 60 cm H₂O. To evaluate the airway, the following scoring system was used: 1 = easy (immediate effective ventilation); 2 = difficult (effective venti-