I am now left with a hoarse, weakened voice, which I assume will be transitory. Unfortunately I also now have fairly severe symptoms of a prolapsed cervical intervertebral disc, with cervical pain and pain in my arm. I deeply regret not informing my anesthetic colleagues of my relatively immobile neck.

I am writing to suggest that inquiries as to problems with neck mobility routinely be solicited with as much zeal as are inquiries regarding false teeth, allergies, or cardiovascular disease.

Barry Shandling MB CHB FRCS(ENG) FRCS(C) FACS
Toronto, Ontario

Posterior-beveled vs lateral-beveled tracheal tube for fibreoptic intubation

To the Editor:

The fibreoptic bronchoscope (FOB) or a gum elastic bougie are frequently used to facilitate tracheal intubation in patients with a difficult airway.¹⁻⁵ However, advancing the tube into the trachea over the flexible FOB or the gum elastic bougie may often be hindered at the level of the larynx. The present report compares the success rate of advancing a conventional left-beveled tracheal tube to that of two models of a posterior-beveled tube during oral fibreoptic tracheal intubation. The Figure depicts the bevel design of the three tubes used in the study.

Twenty-seven adult patients undergoing elective surgery were enrolled in the study. Patients having a history or suspicion of difficult tracheal intubation were excluded. Anesthesia was induced with *iv* propofol 2 mg·kg⁻¹, fentanyl 2 µg·kg⁻¹, rocuronium 0.6 mg·kg⁻¹. In all patients, an 8-mm Berman intubating airway was inserted before introducing the Olympus LF2 FOB (4.0 mm outer diameter). In Group I (17 patients), we compared ease of advance over the FOB of the standard left-beveled Mallinckrodt tube (Figure A) with the Parker Flex-TipTM tipped tube (Figure B). In Group II, (ten patients) we compared advancing of the Mallinckrodt tube with the modified (by the authors) posterior-beveled tube (Figure C). In Group I, the success rate of advancing the tube on the first attempt was significantly higher with the Parker tube (13/17), than with the Mallinckrodt tube (7/17; $P < 0.05$). In Group II, the success rate was significantly higher with the modified Parker tube (10/10), than with the Mallinckrodt tube (5/10; $P < 0.05$). However, the incidence of successful advance of the Parker tube (13/17) *vs* the modified Parker tube (10/10) was not statistically different.

FIGURE The bevel design of the three tubes used in the study A, A standard left-beveled 7.5-mm Mallinckrodt medical tube (Athone, Ireland); B, A 7.5-mm Parker Flex-TipTM endotracheal tube (www.parker-medical.com) which was designed to have a posterior bevel and an anterior flexible tip; C, A 7.5-mm posterior-beveled tracheal tube. The authors cut the anterior Flex-Tip of the Parker tube, the edge was then polished and the tube was resterilized.

Advancing an endotracheal tube over a FOB into the trachea may be difficult in 23% to 46% of patients.² The factor implicated in the difficulty of advancement is the gap between the leading edge of the standard tube and the FOB. This gap allows the tip of the tube to catch on the right aryepiglottic fold, right vocal cord or the tip of the epiglottis. Alterations in the design of the tip of the endotracheal tube would be expected to influence the ease of advancing the tube over a gum elastic bougie or a FOB.³⁻⁵ The Parker Flex-TipTM tube with its posterior-bevel and flexed tip is conceived to pass easily through the glottis. Our findings show that this is the case. This may be attributed to the posterior bevel of the tube per se, as was demonstrated by the success rate achieved with the modified posterior-beveled tube without the Parker tip. With the posterior-beveled tube, the tip of the tube lies anteriorly and stays in close contact with the insertion cord of the FOB, which makes the tube less likely to catch on any of the laryngeal structures.

Anis Baraka MD FRCA
Marwan Rizk MD
Musa Muallem MD
Sania Haroun Bizri MD
Chakib Ayoub MD
Beirut, Lebanon

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Use of a laryngeal mask in acute airway obstruction after carotid endarterectomy

To the Editor:

A potential complication associated with carotid endarterectomy is airway obstruction requiring intubation of the trachea in the postoperative period. This is the result of tissue swelling and/or bleeding into the neck.^{1,2} Fifteen hours after right carotid endarterectomy, a 67-yr-old gentleman developed a hematoma of the neck, with stridor. He was immediately transferred to the adjacent operating room in a left lateral semirecumbent position in order to secure his airway and perform hemostasis. Monitoring employed was electrocardiography, pulse oxymetry, capnography, and invasive arterial blood pressure. Without any sedation and with the patient in the same position, awake endotracheal intubation was attempted with fiberoptic bronchoscopy after three lidocaine sprays on the pharyngeal structures. Generalized massive swelling of the airway was observed, and two minutes after the beginning of the procedure, the patient developed a complete airway obstruction with acute blood desaturation. The neck wound was opened and blood clots evacuated without improvement. Direct laryngoscopy confirmed massive bilateral airway swelling, especially in the posterior aspect of the pharynx, with-

out any visualization of laryngeal structures. External mask ventilation was impossible. Blood saturation fell to around 50% at that time; a 14G needle was inserted through the cricothyroid membrane and connected to the anesthesia circuit (F_IO₂ 1.0) with rapid improvement of blood saturation. A #5 laryngeal mask was then inserted and spontaneous ventilation of the patient resumed without difficulty. The patient, who had lost consciousness at the time of blood desaturation, woke up again. Anesthesia was then induced with sevoflurane and a tracheotomy was performed. Recovery was complete and uneventful. We postulate that insertion of the laryngeal mask helped alleviate airway obstruction secondary to massive tissue swelling and may be attempted in the urgent management of airway obstruction after carotid endarterectomy.

René Martin MD FRCP

Yoland Girouard MD

Daniel J. Côté MD FRCP

Sherbrooke, Québec

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Effets des transferts intra-hospitaliers de patients traumatisés crâniens graves sur les paramètres de perfusion cérébrale

Au rédacteur en chef,

Le transfert intra-hospitalier des patients de réanimation est source d'aggravations cliniques^{1,2} et fait l'objet de recommandations.³ Le but de ce travail était d'évaluer les effets du transport intra-hospitalier de patients traumatisés crâniens graves (TCG) initialement stabilisés sur les paramètres hémodynamiques cérébraux.

Onze transferts intra-hospitaliers ont été étudiés de façon prospective chez neuf patients. Il s'agissait de patients TCG en état stable et devant bénéficier d'un examen scannographique non urgent. Tous étaient pris en charge conformément au protocole du service