blood gases. In edematous patients cannulation of peripheral arteries and veins becomes difficult, owing to the presence of excessive perivascular interstitial fluid. Thus, arterial pulsations become feeble and at times impalpable. This leads to repeated attempts at cannulation and even failure.

A 26-yr-male patient with myeloid leukemia in accelerated phase with massive splenomegaly and anasarca was admitted for splenectomy. Following intubation, right radial artery cannulation was attempted with a 22 G cannula. It was difficult to palpate the radial artery, which was punctured on the third attempt but could not be cannulated. Thereafter, pressure was applied over the puncture site for two minutes to prevent hematoma formation. Once the pressure was released, there was a depression at the site due to redistribution of edema fluid and the radial artery was easily palpated. Subsequently, the artery could be punctured and cannulated easily on the second attempt.

In patients with pitting edema there is exudation of fluid in the interstitial space. Neonates and more so preterms have relatively more total body fluid (interstitial fluid).¹ Displacement of perivascular interstitial fluid by pressure over the peripheral artery makes the course of the artery visible, rendering cannulation under direct vision easy in pediatric patients.² Although the radial artery lies deep to the deep fascia, the overlying interstitial fluid can be displaced by applying pressure, making arterial palpation easy and facilitating cannulation.

A. Agarwal MD
D. Sahu MD
N. Bose MD
Lucknow, India

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Airway loss during tracheostomy

To the Editor:

We read with interest the case report by McGuire *et al.*¹ We agree that the jet ventilation/airway exchange

catheter employed during endotracheal tube exchange in patients with a difficult airway,² appears useful during elective tracheostomy. We describe a rapid method of re-establishing the airway in patients who suffered emergency airway loss during/after tracheostomy.

In the first patient, who had just undergone a reconstructive procedure over the face and neck, the tracheostomy tube became dislodged during transport. Attempted reinsertion failed due to severe neck edema. Two patients with neck tumours suffered airway loss during tracheostomy for prolonged intubation. Re-insertion of the tracheostomy tube was not possible and they could not be ventilated.

In all three cases, we successfully secured the airway simply with the use of a finger! The index or middle finger was inserted through the tracheostomy incision, the fingertip palpating through layers to locate the tracheal incision. Feeling the tracheal rings confirmed passage into the trachea. Alternatively, the cervical vertebral bodies may be located first, traced to the esophagus and trachea, and then along the trachea to locate the incision. Obviously, once the finger is in the trachea, there is no room for a tracheostomy or endotracheal tube. Therefore, a gum elastic bougie (Rüsch, Willy Rüsch AG, Kernen, Germany) is guided into the trachea alongside the finger and placement confirmed by palpation. An endotracheal tube is then threaded over the bougie. The time taken to regain the airway was between 20 to 40 sec. Effective ventilation was re-established in all three patients and none suffered any neurological sequelae.

When faced with difficult airways, sometimes a simple manoeuvre is all that is required. The anesthesiologist's fingers, sensitive and readily available, should not be forgotten, especially when more sophisticated equipment is not on hand.

Ka-Shun Cheng MD
Taipei
Ju-Mei Ng MMED
Singapore

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REPLY:

We thank Cheng and Ng for their comments.

Our case report dealt with a different situation than