vasopressors and early surgery will help prevent morbidity and mortality.

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On smooth extubation without coughing and bucking

To the Editor:

Having just received the Journal and read Dr. Orlando Hung's editorial¹ and Dr. Michael Stix *et al.*'s article² about trying to achieve smooth emergence from anesthesia and extubation (by intra-tracheal lidocaine and exchanging an endotracheal tube (ETT) for a laryngeal mask prior to emergence), I would like to suggest another relatively simple way of achieving such goals.

Whenever I want to extubate a patient quite awake at the conclusion of anesthesia without all the coughing and bucking, I prepare an ETT that will allow me to instill 2% lidocaine into the trachea prior to extubation.

A 3.5 or 5 F.G. infant feeding tube is secured at its distal tip with about 6 cm length of 1 cm "Micropore" tape to the ETT one cm above the cuff, with the end hole of the feeding tube free from obstruction. The feeding tube is then wound around the ETT snugly and the upper part of the feeding tube is secured again with 1 cm "Micropore" tape to the upper part of the ETT, at the 22 or 24 cm mark of the ETT.

While the patient is still paralyzed or in a deep anesthetic state, I can instill 4 mL of 2% lidocaine through the infant feeding tube, wait a few seconds, then deflate the ETT cuff to let the lidocaine run down into the trachea below the ETT cuff, ventilate the patient once with the cuff still deflated, then re-inflate the cuff. This should provide adequate topical anesthesia to the trachea for about 15 to 20 min. If time to extubate has gone beyond 15 min, repetition of the above manoeuvre before the 20 min "deadline" is up will extend the "tracheal anesthesia" state.

FIGURE Endotracheal tube with feeding tube.

This method has served me well over the last few years. I have learned to time the instillation of lidocaine, so that when the patient is awake enough to be safely extubated, the trachea is still anesthetized topically. A word of caution is warranted. All the suctioning of the oropharynx should be completed before reversing or lightening anesthesia as the oropharynx is not anesthetized topically. Also I have not used this method yet in patients intubated nasotracheally.

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- 1 Hung Q Understanding hemodynamic responses to tracheal intubation (Editorial). *Can J Anesth* 2001; 48: 723–6.
- 2 Stix MS, Borromio CJ, Sciortino GJ. Learning to exchange an endotracheal tube for a laryngeal mask prior to emergence. *Can J Anesth* 2001; 48: 795–9.

Electroconvulsive therapy with thiamylal or propofol during pregnancy

To the Editor:

We describe our experience of administering anesthesia to a depressive patient during pregnancy for electroconvulsive therapy (ECT) with thiamylal or propofol. A 31-yr-old pregnant (21 weeks and four days) woman underwent ECT 14 times over a period of 65 days. While the patient laid in a supine position in the operation room, anesthesia was induced with either thiamylal (4 mg·kg⁻¹) or propofol (1.5 mg·kg⁻¹) followed