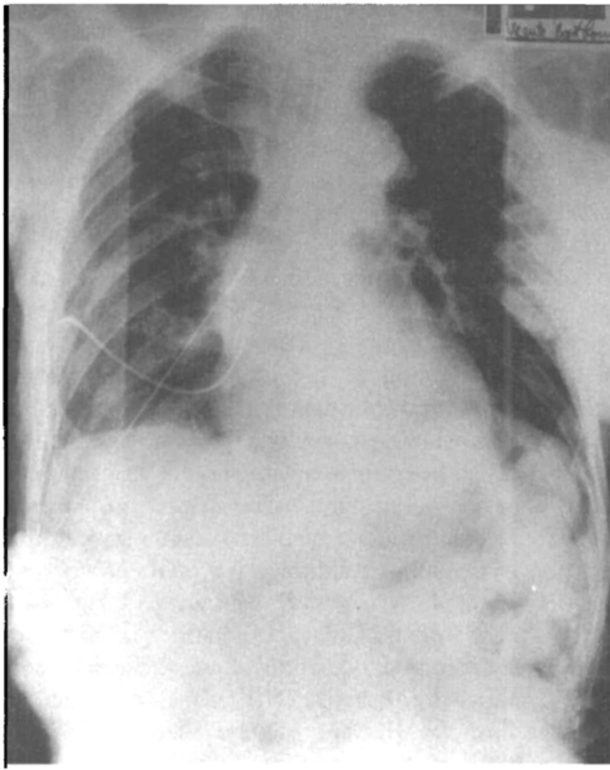

FIGURE Control chest radiograph, with nasogastric tube passing through the thoracic oesophagus

ing altered mental status, preexisting anatomical abnormalities, cervical osteophytes, etc.

Recently, our anaesthesia service was asked to assist in the changing of a feeding tube in a 77-yr-old debilitated man. The tube had been changed six months earlier. After some difficulty in insertion, a chest radiograph showed that thoracic oesophageal perforation had occurred (Figure). No pneumothorax was present and the patient had no respiratory problems. Analysis of fluid aspirate showed: pH 7, glucose 67 $mg \cdot dl^{-1}$, protein 1.3 $g \cdot dl^{-1}$, LDH 189 $U \cdot l^{-1}$ confirming its pleural origin. The tube was repositioned and the patient had no complications.

The difficulty in identifying naso-gastric tube misplacement is compounded by the minimal resistance encountered as the tube enters the lung in patients with weak or absent gag and cough reflexes.[2] On the other hand, feeding tubes may be left in place for six weeks[3] or, in our case, for six months. This may irritate the oesophageal mucosa and also predispose to oesophageal perforation.

E. Carrillo MD PhD
J. Muoz MD
J.A. Tortosa MD PhD
Murcia, Spain

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A practical tracheal tube tie

To the Editor:

Endotracheal tubes once placed, are usually fixed inexpensively with either adhesive tape or a cotton tie. The disadvantage of a cotton tie is that it may slip on the tube so allowing migration in the trachea. Our institution supplies half inch waterproof, zinc oxide based, adhesive tape to secure ET tubes. The type of fixation becomes a problem for patients who have very thick beards that leave no skin exposed on the cheeks or neck. If there are no cotton ties or ribbon gauze to hand, a simple solution is to take a surgical mask and place it under the occiput of the patient. The four cotton ties are long enough to reach around an adult's face and lasso around the tube providing a sturdy double tie. This technique is a lot less expensive than using Velcro straps that are commercially available for tube fixation.

R. Alexander FRCA
D. Gleason CRNA
Duke University Medical Centre
Durham, North Carolina, USA