position and bent at right angles, 7 cm from the tip. The Trachlight-tracheal tube (TL-TT) was inserted into the nostril with the Trachlight handle at 90° to the sagittal plane and advanced until light was seen in the oropharynx when the handle was rotated 90° into the sagittal plane. After further advance, a blurred light was seen lateral to the cricothyroid membrane. The TL-TT tip was maneuvered anteromedially, a bright point of light was seen at the cricothyroid membrane, the stylet was withdrawn and the TT advanced into the trachea. Placement was confirmed by capnography. The time taken was 12 sec.

This case illustrates that atraumatic Trachlight-guided nasal intubation is possible with the stylet in position. Increased risk of nasal trauma without the stylet may be is outweighed by a higher success rate, less pharyngeal trauma and fewer head-neck manipulations.

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Reply:

I must thank Dr. Agro for his suggestion regarding the use of Trachlight® for nasotracheal intubation. During the development of the Trachlight®, we found that nasotracheal intubation could be easily performed without the rigid stylet. Occasionally, it was necessary to flex the neck, apply pressure to the larynx, or inflate the ETT cuff to align the ETT tip with the glottis during intubation. We tested this technique in 109 patients. Using the Trachlight® without the rigid internal stylet, intubation was successful in all but one patient. It was difficult to elevate the ETT tip anteriorly to align with the glottis with this patient. This difficulty was overcome by using the rigid stylet to form the "hockey stick" configuration as described by Dr. Agro. In my opinion, most Trachlight® nasotracheal intubations can be effectively performed without the stylet. However, if it is difficult to elevate the ETT tip to align with the glottis of the patient who has an "anterior larynx" during intubation, nasotracheal intubation can be repeated with the rigid Trachlight® in the "hockey stick" configuration. Alternatively, the anterior elevation of the ETT tip with the pliable Trachlight® can be achieved with the use of the Endotrol®,[1] or a nylon string fastened at the distal end of the Trachlight®.[2]

I welcome Dr. Agro's effort in studying the light-guided nasal intubating technique and I strongly encourage anesthesia staff and trainees to practice this technique in appropriate patients regularly. The payoff will become evident when a difficult or challenging situation arises.

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Thermal injury with pulse oximeter probe in hypothermic patient. Pulse oximeter probe burn in hypothermia

To the Editor:

Oxygen saturation monitoring with pulse oximeter is a standard practice in anesthesia.[1,2] Many reports of thermal injury with pulse oximeter are reported and various mechanisms of injury have been proposed.[1,3,4,5] This report highlights the risk of thermal injury in hypothermic patient with pulse oximeter.

A live related renal recipient underwent general anesthesia with standard monitoring. Patient became hypothermic during surgery and required elective ventilation for short duration in PACU. He became normothermic. Thereafter he was extubated and shifted to kidney transplant unit with stable vitals.

Next morning, on the dorsum of thumb, and web between thumb and index finger (the site of probe application) two bullous eruptions were noticed. The blisters were dressed with framycetin, which subsequently healed without complication.

Burns following pulse oximeter is uncommon but not rare. The proposed mechanisms of oximeter probe burns are: increased probe temperature either inappropriate combinations or probe overheating, due to mechanical