

FIGURE 1 A model of the cause of airway obstruction. The spiral tube was pulled by the surgeon, and the beveled end of the tube contacted the tracheal wall.

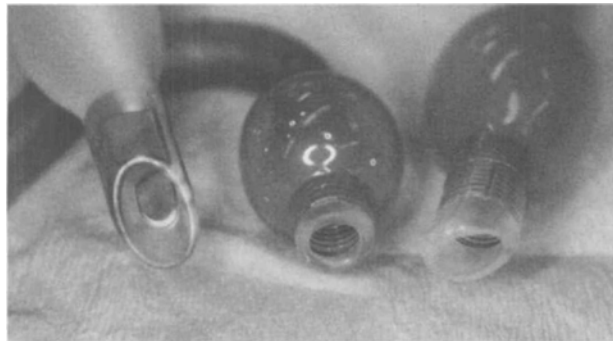


FIGURE 2 Beveled end of endotracheal tubes. Normal tube with Murphy eye (left), J-shaped spiral tube (middle) and spiral tube (right).

angle, and does not contain a sharp edge (Figure 2). Therefore, the beveled end can be easily obstructed by the tracheal wall. We propose that every endotracheal tube features a Murphy eye.

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#### Reference

- 1 *Murphy FJ*. Two improved intratracheal catheters. *Anesth Analg* 1941; 20: 102-5.

### *Similar invasive procedures, but different techniques. (A potential disaster.)*

A 62 yr old woman with a history of craniotomy for aneurysm clipping presented for redo craniotomy. The anesthesia induction and maintenance were uneventful with the exception of sudden difficulty in maintaining adequate hemostasis. Intraoperative coagulation studies were found to be highly abnormal despite the normal preoperative levels. Unbeknown to the anesthesiologist, the neuroradiology team had infused more than 2000 u of heparinized solution into the patient. Protamine and fresh-frozen plasma reversed the abnormality and the patient made an uneventful recovery.

This case highlights the importance of keeping a watchful eye on all health care personnel performing procedures on anesthetized patients. In this case, the interventional radiologist did not use a transducer system to keep the femoral artery patent. Instead, he relied on a simple *iv* line from a pressurized bag. We did note that no transducer system was being used, but ignored it. When we realized that the cause of the intraoperative "oozing" was due to excess heparinized saline solution given through the femoral sheath, we closed it and inserted our own transducing system. Now, we routinely hand the interventional radiologist our transducer system when they are inserting a femoral sheath.

Two points are worth noting (1) keep a watchful eye on all health care personnel working on anesthetized patients, and (2) understand the limitations and potential problems of equipment and/or techniques that other health care providers use.

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### *Unexpected left atrial occlusion secondary to esophageal tumour terminates anesthesia*

To the Editor:

A 70 yr old lady (ASA 1, 156 cm, 54 kg) with an esophageal carcinoma presented for esophagectomy. Preoperative chest CT was not performed. A thoracic epidural was placed at T<sub>7,8</sub> with 3 ml bupivacaine 0.5% administered as a test dose uneventfully. After five minutes anesthesia was induced with 100 µg fentanyl and