

Kristensen reduced two-thirds the rate of resistance to passage of the tube into the trachea by comparing the PFT with the standard tube (Portex™) during fiberoptic orotracheal intubation.⁵ Utilization of thinner fibrescopes, or greater ID tubes is possible because the PFT mainly reduces the gap between the scope and the tube (Figure). Reduction of the gap, joined to the use of flexible tubes are the main recommendations given by Asai *et al.*¹

In conclusion, the PFT tube may be useful for nasotracheal fiberoptic intubation in awake patients.

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Adopting ultrasound to facilitate central venous catheterization

To the Editor:

We commend Drs. Saxena and Sharma for their forthright report of yet another complication related to central venous catheterization (CVC).¹ In response to their query, we believe the most central question is when, if ever, will the use of ultrasound (US) to guide CVC become commonplace, if not the standard of care. The literature is abundant on this topic. Guiding

CVC with US results in fewer needle passes, less time to complete the procedure with a higher success rate and fewer carotid punctures. On the other hand, anatomic landmarks, the traditional approach to CVC, are too variable to allow similar results.² In addition, determining the size of the internal jugular vein and its relationship to the carotid artery, which is crucial to avoid complications, cannot be accomplished without US. While the use of US for CVC has not been studied in all conditions and circumstances (e.g., cardiac arrest), there is little reason to suspect that clearly depicting the anatomy with US would not compare favourably to "blind" techniques.

The Agency for Healthcare Research and Quality recently assessed 79 medical practices and deemed 11 of them to have sufficiently strong evidence supporting specific recommendations.³ One of these was the recommendation that US be used for CVC. The recently published closed-claims analysis of complications related to CVC suggests that malpractice suits related to vascular access are increasingly more common than claims related to vascular use/maintenance.⁴ Nevertheless, for a variety of reasons, the vast majority of clinicians do not use US for CVC. Ultrasound devices are commonplace in medicine, and not prohibitively expensive, so availability is at most only part of the problem. The greater problem, we believe, is that the adaptation of practice approaches such as the use of US for CVC, which are supported by sound and convincing evidence, will remain a chief challenge in contemporary medicine.

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