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### *Another technique to facilitate insertion of the ProSeal™ laryngeal mask airway*

To the Editor:

I am writing further to Dr. Laurence W. Lee's correspondence regarding the use of a Satin-Slip® stylet to facilitate ProSeal insertion.<sup>1</sup> I have been using a variation of this reported technique for several years now and it is a slight refinement of Dr. Lee's description. The portion of the stylet that is not advanced into the gastric port (esophageal lumen) can be bent 180° back onto itself to form a short arm. The short arm is advanced into the ventilation port. The configuration of the stylet is now akin to the stylet used for double lumen tube insertion for lung isolation procedures. The advantages of this configuration are that it resists rotation of the ProSeal on its short axis (avoiding direction into a pyriform fossa), prevents the stiff stylet from inadvertently protruding beyond the gastric port distal outlet, and finally, allows the stylet ProSeal to be bent into the same curve as an intubating laryngeal mask airway if the operator prefers that method of insertion.

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#### Reference

- 1 Lee LW. Insertion of the LMA ProSeal™ using the Satin-Slip® intubating stylet. *Can J Anesth* 2007; 54: 81–2.

### *Extension of a shortened endotracheal tube*

To the Editor:

Changing an endotracheal tube (ETT) in critically ill patients with severe airway edema is challenging and potentially life threatening. We describe an alternative to tube exchange for an ETT that was too short in length.

A 170 cm tall pregnant 35-yr-old female at 30 weeks gestation was involved in a motor vehicle acci-

dent. Although initially awake, her condition deteriorated. Awake intubation using direct laryngoscopy by attending anesthesiologists was successful on the third attempt with a 7.0-mm internal diameter (ID) tube; the Cormack grade was 3. The ETT was cut below 26 cm for unknown reasons.

Emergency laparotomy confirmed placental abruption, fetal death and upper abdominal bleeding. Splenectomy and packing was done. Despite these procedures and massive transfusion, the patient continued to hemorrhage and experienced three episodes of pulseless electrical activity. The following day she was profoundly edematous but obeyed commands.

On the chest radiograph, the ETT was 4.6 cm above the carina but could not be advanced because the connection was at the patient's lips. A periodic air leak was noted and the possibility of tube exchange was considered. Redundant tubing in the mouth was ruled out by direct examination of the oral cavity and bronchoscopy. A tracheotomy was considered but neck edema and cervical spine precautions would have made the procedure challenging. It was decided not to use tube exchange catheter because of upper airway edema, unintentional tracheobronchial injury and possible inability to re-insert an ETT.<sup>1</sup> Attempts to pass an ETT beside the existing tube via a bronchoscope<sup>2</sup> were considered unlikely to be successful. Another option, telescoping a second ETT over the existing tube, was proposed.

A 9.5-mm ID ETT could easily telescope over a 7.0-mm tube. Securing the tubes together was accomplished by use of nylon ties applied by a cable tie gun. Once secured, the tubes could not be pulled apart. In the operating room, with a difficult airway cart and Sander's jet ventilator present, preparation for tracheotomy was made. After preoxygenation, the connector of the existing tube was removed. A tube exchange catheter was placed in case of inadvertent removal and to serve as a 'stent' to prevent tube compression during nylon tie placement. The *in situ* tube was lubricated and a cut upper half of a 9.5-mm ETT was easily advanced and secured by nylon ties (Figure). The procedure was well tolerated. Final positioning was performed under bronchoscopic guidance. No further airway leak occurred. The added extension was shortened to match the length of suction catheters.

The patient's course in the intensive care unit was complicated but she was successfully extubated from the ventilator and hybrid tube on day 15. Subsequent follow-up found no deficits except unilateral hearing impairment.

It is unfortunate that this problem arose since there is no compelling reason to cut endotracheal