

patient, concomitant flexion of the neck of the patient facilitated tracheal tube placement.

In conclusion, we suggest consideration of this method for nasotracheal intubations when conventional use of Magill forceps fails to achieve successful ETT placement in the trachea.

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Inopportune breakage of an endotracheal tube T-connector

To the Editor:

Structural endotracheal tube failures have been reported in clinical events despite the standard practice of visual inspection of the device for physical defects and testing of the cuff prior to use. We present a case of fracturing of the T-connector piece on an Intermediate Hi-Lo® 7.5 mm internal diameter endotracheal tube (Mallinkrodt, St. Louis, MO, USA). This is an unusual device failure which has not previously been described.

During a rapid sequence intubation for a patient at high risk for aspiration, the T-connector broke upon removal of the stylet. Fortunately, this did not affect cuff inflation, so the airway was protected and the initiation of ventilation was only briefly delayed while the T-connector was removed from a second endotracheal tube.

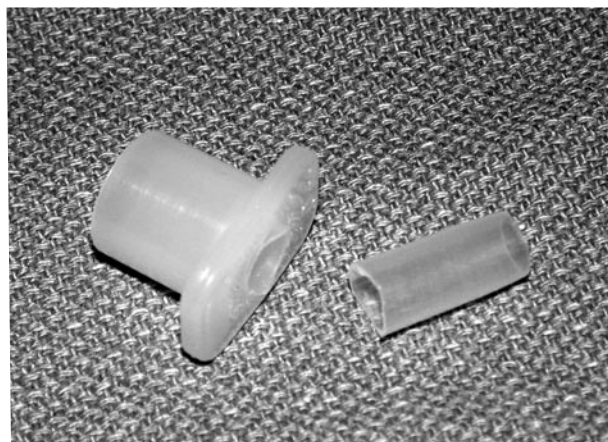


FIGURE A fractured endotracheal tube T-connector.

The practice of visual inspection of the endotracheal tube and testing the integrity of the cuff has been shown to miss several types of endotracheal tube malfunction; including damage to the pilot ball-valve which may occur with testing of the cuff,¹ small leaks along the pilot tube,² and occult intraluminal foreign body remnants from the manufacturing process.³ Since the male-end of the T-connector is within the lumen of the endotracheal tube, defects may not be apparent upon visual inspection. The standard practice of having a second endotracheal tube prepared and ready is necessary since damage to delicate parts can occur during insertion. This was the rare instance where the second endotracheal tube could be scavenged for parts to repair the first.

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