Tracheal Tube Advancement Over the Fiberoptic Bronchoscope: Size Does Matter

To the Editor:

We read with interest the article describing the use of a sleeve to facilitate tracheal tube advancement over the fiberoptic bronchoscope (1). Ayoub et al. used 7.5- and 8.0-mm ID tracheal tubes over a 3.8-mm OD bronchoscope, creating a huge gap between the tracheal tube and the bronchoscope. To obliterate this gap, Ayoub et al. used a sleeve to provide added thickness to the insertion cord.

The problem of tracheal tube “hang up” can be totally aborted, or at least its incidence extremely minimized, by properly matching the fiberscope and the tracheal tube sizes from the start. This obviates the need for use of additional devices that may be associated with potential problems. The sleeve described by the authors can be dislodged into the airway, especially if the bronchoscope is well lubricated, which is usually the case. Dislodgement of the sleeve beyond the lens can also lead to sudden loss of the view and make further visualization impossible unless an assistant pulls the sleeve back and holds it in position. In order to prevent dislodgement of the sleeve, the authors used a silk tie. If this tie becomes loose during the procedure, the sleeve can still be dislodged and if the tie is too tight it can damage the light bundles, the suction channel or the bending control wires. The manipulation of the insertion cord with the sleeve added to it may become more difficult through the curves of the airway than when using the insertion cord alone. Finally, poor lubrication between the sleeve and the scope can lead to intussusception of the outer plastic cover of the bronchoscope upon trying to remove the sleeve at the end of the procedure (2).

We should not abrogate the principles of good fiberoptic technique. With adequate preparation of the tracheal tube and choosing the largest scope in which the tube can easily fit, this problem should rarely be encountered. When it does occur, pulling the tube back and gently rotating it 90 degrees counterclockwise before readvancing will allow easy passage in almost all of the patients, as Schwartz et al. (3) reported, without the need to use any additional devices.

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References

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In Response:

Thank you for referring to us the letter by El-Orbany et al. concerning our report “advancing the tracheal tube over a flexible fiberoptic bronchoscope by a sleeve mounted on the insertion cord” (1).

As they mentioned in their letter “with adequate preparation of the tracheal tube and choosing the largest scope in which the tube can easily fit, this problem should rarely be encountered. When it does occur, pulling the tube back and gently rotating 90 degrees counterclockwise before readvancing will allow easy passage in almost all of the patients, as Schwartz et al. (2) reported without the need to use any additional devices. However, in our department as well as in many other institutions all over the world, the 3.8-mm fiberoptic bronchoscope may be the only available size, and hence advancing the endotracheal tube may fail despite the 90-degree counterclockwise rotation. In this situation, advancing the endotracheal tube into the trachea can be facilitated by other maneuvers such as the double setup endotracheal tube proposed by Rosenblatt (3), or as suggested in our report, by mounting a conical sleeve over the insertion cord of the fiberoptic bronchoscope; the dislodgement of the sleeve is prevented by the proximal tight silk tie (1). The presence of the sleeve centralizes the tube in front of the glottis and decreases the likelihood of impingement on the arytenoids, which facilitates advancement of the endotracheal tube into the trachea.

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References

Propofol Reduces Idiopathic Prolonged QT Interval and QT Dispersion During Implantation of Cardioverter Defibrillator

To the Editor:

We have read with interest the recent publication by Weinbroum et al. (1), which demonstrates that halothane, isoflurane, and fentanyl increase the defibrillation energy thresholds, compared with subcutaneous lidocaine plus intermittent small dose IV propofol that minimized these thresholds, during the implantation of cardioverter defibrillator in humans.

However, we would like to draw the authors’ attention to the statement, which refers to our report (2). In their discussion they quote: “Interestingly, although propofol may cause the prolongation of the QT interval during the implantation of an ICD—an event that did not occur in our study—this has not kept the drug from gaining the reputation as being safe for this procedure, even in patients with severe left ventricular dysfunction.”

Our report clearly indicates (see Results) that propofol decreases the QT interval and QT dispersion in patients with idiopathic prolonged QT interval and QT dispersion.

Furthermore, we conclude that: “propofol combined with local analgesics may be a safe alternative technique for patients with idiopathic prolonged QT interval and QT dispersion” (2).

Our decision to use midazolam as premedication and propofol for conscious sedation was influenced by our reported results on healthy ASA I-II patients that showed that neither midazolam nor propofol had any significant effect on QTc interval (3).

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References

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