local haemorrhage, ecchymosis, gum bleeding, headache, and dizziness.

Obstetric consequences occurred in five patients (two patients moderate and three severe problems) (Table 1). Five developed vaginal bleeding. Abruptio of the placenta occurred in three cases, uterine contraction in one case, decreased fetal movements was present in one case, absence of fetal heart beat in one case, and fetal death in one case.

Snakbite is not common in pregnant women; however, the obstetric consequences are severe and related to severity of the envenomation.

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Positioning the tracheal tube during percutaneous tracheostomy: another use for videolaryngoscopy

Editor—When preparing a patient for percutaneous dilational tracheostomy, correct positioning of the endotracheal tube is important. During the procedure, it is possible to puncture the cuff with the needle used to infiltrate local anaesthetic or, more commonly, the Seldinger needle. Tracheal tube cuff puncture can lead to failure of ventilation, loss of positive end-expiratory pressure, and possible aspiration of gastric contents blood or secretions.

To minimize this risk on our intensive care unit, it is our normal practice to withdraw the endotracheal tube under direct laryngoscopic vision until the cuff is visible at the vocal cords. The tube is then manually held in place by the anaesthetist while the procedure is carried out. This ensures that the cuff and tube tip lie above the insertion site of the tracheostomy and not only minimizes the risk of accidental cuff puncture but also of the endotracheal tube itself interfering with placement of the tracheostomy tube. However in our experience, patient repositioning or movement can result in tube dislodgement and this can result in an air leak which often necessitates tube repositioning under direct laryngoscopy, or even re-intubation.

Videolaryngoscopy has been demonstrated to give equivalent or superior laryngeal visualization in routine and difficult airways.1 We have now carried out four percutaneous tracheostomies using videolaryngoscopy (Glidescope, Verathon Medical, Aylesbury, UK) to position the endotracheal tube before commencing the procedure. All patients were known Cormack and Lehane grade 1 or 2 intubations. The Glidescope was inserted and the larynx visualized. The pharynx was gently suctioned of secretions. The endotracheal tube cuff was then deflated, allowing withdrawal of the tube under direct vision until the top of the cuff is visualized at the level of the cords (Fig. 1). The pilot balloon was then gently re-inflated until there was no leak. The scope was left in position during the procedure allowing direct visualization of the larynx by both operator and anaesthetist and allowing for further tube repositioning as necessary during the procedure.

The advantages of this technique are, first, that videolaryngoscopy offers good visualization of the larynx even with the cervical spine fully extended. Tube position can be visualized continuously and the shape of the Glidescope blade causes minimal interference with the conduct of the tracheostomy, in comparison with the handle of a Mcintosh laryngoscope. Finally, if the operator wishes to view the tube position (e.g. when working with a more junior colleague), the screen can be positioned to be in view of both anaesthetist and operator. We recommend considering the use of this technique as a means to minimize the incidence of inadvertent cuff puncture and tube dislodge ment during percutaneous tracheostomy.

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