However, the mechanism of pulmonary oedema in humans is, to the best of our knowledge, not known. If increased hydrostatic pressure is important, then the use of furosemide can be justified. Therapy directly aimed at neutralizing PGE$_2$ is currently experimental. Although estimation of blood loss during major bleeding may be difficult, we do not think that our patient developed pulmonary oedema due to overtransfusion as we are confident that we did not infuse a greater volume of i.v. fluid than the amount of blood lost, and she had a normal cardiac function. We are not aware of any report suggesting that pulmonary oedema might be directly caused by HES solutions.

M. Hagenaars*
J. T. A. Knape
E. M. J. M. Backus
Beverwijk, Utrecht and Enschede, The Netherlands
*E-mail: hagena7@xs4all.nl

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Pathway of the tracheal tube and complications of nasal intubation

Editor—We read with interest the paper of Ahmed-Nusrath and colleagues¹ who compared the frequency with which the preformed, reinforced, and thermosoftened preformed tubes pass through upper and lower pathways in nasal intubation. They concluded that the tracheal tubes, particularly preformed tubes, frequently took the less favourable pathway, in spite of specific attempts to avoid this. However, several issues of study design merit further comment. The Mallinkrodt™ preformed nasal tube is a cuffed PVC tube with a stiff texture and requires the thermosoftening treatment before intubation to decrease the incidence of epistaxis and nasal damage.² However, it must be emphasized that the tube will cool to the ambient temperature of the room very quickly and consequently, become stiffer. Accordingly, if the intubation is to be delayed for a long time because of a difficult manipulation, the positive effects of the thermosoftening tube will be negated by the time taken to attempt reintubation.³ This may be a reason for no significant differences in all observed variables between the preformed and thermosoftened preformed tubes.

We are also very interested in the nasal tube size selection methods, in which sizes 7 and 6 mm tubes were used for male and female patients, respectively. They seemed to have selected smaller tube sizes for the adult patients with a mean weight of >70 kg compared with those used in other previous studies.³–⁷ In the vast majority of adults, sizes 7–7.5 mm nasal tube can smoothly pass the nares.

On the basis of the assumption that a 50% reduction in the tubes passing through the upper nasal pathway would be a clinically important difference between the groups, a sample size of 30 patients each group was selected to detect this difference with a power of 80% and a $P$-value of 0.05. However, the power of the study is not sufficient to detect a statistically significant in the incidence of epistaxis between the groups, although the number of epistaxes caused by passing tubes was apparently greater in the use of the preformed tubes than in the use of the reinforced and thermosoftened preformed tubes. The small sample size may have prevented authors from excluding a type II error when comparing the incidences of epistaxis between left and right nostril intubations, and evaluating the proportions of the preformed and thermosoftened preformed tubes causing epistaxis between upper and lower nasal pathways. Therefore, we do not agree the conclusion of this study that the two nostrils have a similar incidence of epistaxis, when the tube is passed through either nostril with the bevel facing to the left.

F. S. Xue*
X. Liao
Y. M. Zhang
Beijing, People’s Republic of China
*E-mail: fruitxue@yahoo.com.cn

Editor—We thank Professor Xue and colleagues for their interest in our article.¹ The purpose of our investigation was to determine the frequency with which tracheal tubes traversed the upper nasal pathway, because when they traverse this pathway, there is a far greater chance of damage to the middle turbinate,⁴ ⁸ than if they traverse the lower nasal pathway. The observation that intubation of the upper nasal pathway caused significantly more epistaxes was an unanticipated bonus, but it was not the reason for our study. We reported this significant event in our paper and added the other non-significant epistaxis data for completeness. We did not claim to have proved or to have
disproved any epistaxis hypothesis, but merely indicated when our data were consistent with other work.\textsuperscript{5} Overall, there was a significant difference between epistaxis in upper and lower pathway cannulation, but as we indicated in the paper, the number of preformed and thermosoftened preformed tubes passing though the lower pathway was too small (16.7\% and 20\%, respectively) for meaningful statistical analysis on their own. However, when reinforced tubes were considered, there was a significant difference between epistaxis in upper and lower pathway cannulation. In a randomized controlled trial, sample size is based on the primary focus of the investigation and not on secondary factors, particularly when the investigators are not aware of the existence of a particular secondary factor. Hence, the possibility of a beta error with regard to the epistaxis data is irrelevant here.

The size of tubes used (7 mm and 6 mm tubes, for males and females, respectively) are perfectly satisfactory for routine nasal intubation. There is seldom any need to resort to 7.5 mm tubes, which are more likely to cause nasal damage.\textsuperscript{9} It is well recognized that stiffening of the tube recurs rapidly as the tube cools, and intubation was performed promptly and without delay.

J. E. Smith*
J. L. Tong
Birmingham, UK
*E-mail: j.e.smith@bham.ac.uk

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Rhabdomyolysis after bariatric surgery: a potentially fatal complication

Editor—Rhabdomyolysis (RML) has been increasingly recognized as a complication of bariatric surgery.\textsuperscript{1, 2} Since 2003, several case reports have described postoperative RML after bariatric surgery, some of them fatal.\textsuperscript{3, 4} We report a case of severe RML in a patient who had undergone bariatric surgery, and whose renal function was preserved despite a very high creatine kinase (CK) concentration. We wish to raise awareness among anaesthetists of this potential and possibly underestimated complication in which early diagnosis can alter the outcome.

A 40-yr-old morbidly obese male (BMI 85) underwent laparoscopic sleeve gastrectomy. His medical history was only significant for sleep apnoea syndrome. The surgery was technically difficult and lasted 360 min. Otherwise, the intraoperative course was uneventful. Immediately after the extubation in the operating theatre, he complained of severe gluteal pain and dependent areas showed erythema and scattered small vesicles. RML was suspected and serial CK measurements confirmed an increase in CK levels (from 475 u litre\textsuperscript{-1} immediately after the operation to 37 422 u litre\textsuperscript{-1} 4 h later) (Fig. 1). Aggressive fluid replacement, urine alkalization, and administration of mannitol were initiated. The patient had a peak CK of 108 700 u litre\textsuperscript{-1} at 24 h. From 48 h, CK levels started decreasing progressively to the baseline on the 10th postoperative day. The renal function remained stable during the entire postoperative period with creatinine <1.0 mg dl\textsuperscript{-1} (Fig. 1). At 15 days, the patient was discharged home fully recovered.

RML is a clinical and biochemical syndrome that varies from asymptomatic increase of muscle enzymes (CK), to acute renal failure (ARF), compartment syndrome, and even death.\textsuperscript{2} RML is produced by injury and necrosis of skeletal muscles and the subsequent release of intracellular toxic substances into the circulation. Increased compressive pressure owing to excessive weight has been recognized as a risk factor in obese patients. The incidence of RML after bariatric surgery is not clear, having been estimated from 1.4\% to 75\%.\textsuperscript{1, 4} Prolonged surgery, extreme surgical positions, ASA physical status III–IV, and the presence of diabetes or hypertension have been identified as factors associated with development of RML.\textsuperscript{3}

The first signs and symptoms have been usually reported during the first 24 h after the injury, although, like in our case, those may appear early. The suspicion diagnosis based on clinical manifestations (reddish-brown urine, gluteal and back pain, and oliguria)\textsuperscript{2, 3} must be confirmed by laboratory studies. A five-fold elevation of serum CK level (>1050 u litre\textsuperscript{-1}) is considered diagnostic.

The subsequent development of ARF, considered as a major prognostic factor in RML, occurs in 20–50\% of