Conflict of interest

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T. C. E. Gale*
M. J. Roberts
P. J. Sice
J. A. Langton
F. C. Patterson
A. S. Carr
I. R. Anderson
W. H. Lam
P. R. F. Davies
Plymouth, UK

*E-mail: thomas.gale@phnt.swest.nhs.uk


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Percutaneous tracheostomy: prospective practice

Editor—We read the prospective evaluation of 6 yr carried out by Dempsey and colleagues.1 The authors called for auditing at the national level to warrant the safety of the procedure. We would like to contribute our experience and update the prospective evaluation at the local regional hospital. Over 11 yr, 666 tracheostomies were performed in a mixed medical/surgical ICU. Of these, 610 were percutaneous, 558 with a Griggs forcep, 57 with a Percutwist dilator, and seven with a single dilator. Most of tracheostomies were performed utilizing an LMA as airway management device, after extubating the patients. We confirm the experience of our colleagues in terms of low incidence of early and late complications, and the high rate of success within the first attempt (97%) or second (99%). The conversion to an open tracheostomy was decided early in the process of preparation, based on landmarks and positioning of the guiding needle (under direct bronchoscopic visualization) and resulted in no cases of failed percutaneous cannulation requiring open tracheostomy. Maintaining direct visualization and strict selection and preparation protocols make the technique safe and successful. This may also be the reason of low rate of long-term complications. Important is also the contribution of clinical simulation and mentored training, in order to attain fast competency.

Conflict of interest

None declared.

D. Cattano*
S. Buzzigoli
M. Genovesi
C. Zoppi
C. A. Hagberg
Houston, USA

*E-mail: davide.cattano@uth.tmc.edu

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Reply from the authors

Editor—We thank Professor Cattano and colleagues for their comments on our study.1 While we accept that patient safety is paramount during any invasive procedure, we do not feel this is necessarily achieved by the use of the laryngeal mask airway (LMA) during percutaneous dilatational tracheostomy. The risk of difficult airway management is high in the general critical care population with difficult intubation described in 8–12%2,3 and severe life-threatening complications in up to 28%.3 Additionally, in our patient cohort, there was an over-representation of head and neck and upper gastrointestinal surgical patients, at higher risk of difficult intubation and gastric aspiration, respectively. Consequently, it is our opinion that maximum patient safety is achieved not with the LMA but utilizing the definitive airway that is in situ at the start of the procedure. We feel that this opinion is borne out by the results presented within our paper.1

With respect to the utility and safety of the Percutwist technique, we have no direct experience. We believe, however, our paper has more than adequately demonstrated the safety profile of the single tapered dilator technique in our patient population.

Conflict of interest

None declared.

G. Dempsey*
C. Grant
T. Jones
Liverpool, UK

*E-mail: ged.dempsey@aintree.nhs.uk
Xylometazoline pretreatment reduces nasotracheal intubation-related epistaxis in paediatric dental surgery

Editor—The recent article by El-Seify and colleagues,¹ which evaluates an admixture of lidocaine gel and xylometazoline in reducing epistaxis after nasotracheal intubation (NTI) in children, has raised several points which deserve further discussion. In the methods, the authors have curiously omitted the estimation formula and size (internal diameter) of cuffed tracheal tubes used in their study. The age range in their study population is from 2 to 6 yr and based on the traditional formula for estimating the size or internal diameter of a paediatric cuffed tracheal tube:² [cuffed endotracheal tube size (mm)= (age in years/4)+3], standardization of tube size would not have been possible. However, the external diameter of tracheal tubes sized 3.5–4.5 mm which are manufactured by P3 Medical Ltd, Bristol, ranges from 4.8 to 6.0 mm. In which case, if tubes of this size were used, the large external diameter at the level of the cuff may have caused greater nasal trauma during insertion. It has been previously shown that NTI performed using larger tracheal tubes may be associated with a higher incidence of trauma and bleeding,³ which may explain the relatively high incidence of persistent epistaxis (9.8%) reported in their control group. My second point also concerns the methods and the inadequate description of how the authors were able to determine the most patent nostril for NTI in paediatric patients. Nasal air-flow assessments using direct questioning is in my experience unlikely to provide accurate or reliable data in pre-school patients. Similarly, patient cooperation with an examination-based assessment of nasal air-flow may be subject to error or observer bias. Interestingly, their results show a significant preference in both groups for intubation via the right nostril (78%). Owing to the poor reliability of air-flow based assessment, I believe that a random method of nostril selection may have provided different results and conclusions to those published. It has previously been shown in adults that fibreoptic nasendoscopy is a more reliable method of determining the most patent nostril than subjective air-flow assessments.⁴ While the results from a comparable paediatric study have yet to be published, a careful and atraumatic fibreoptic examination of the nasal pathways could have been used to confirm the most patent nostril in this study.

Conflict of interest
None declared.

J. L. Tong*
Birmingham, UK
*E-mail: j.l.tong@bham.ac.uk

Reply from the authors
Editor—We thank Dr Tong for his interest in our study and for his comments.¹ The suitable size of nasotracheal tube (NTT) was determined not only on the basis of formula estimation of the size; but also on the physical examination and facial configuration of the child. We agree that the external diameter of NTT manufactured by P3 Medical Ltd, Bristol (a preformed siliconized soft flexible tube), is somewhat bigger than the ordinary polyvinyl chloride (PVC-based) tube. However, a previous study² comparing a silicone-based tube with a PVC-based tube for nasotracheal intubation found that the incidence of epistaxis was 32.5% with silicone tracheal tubes and 80% with PVC tubes. Accordingly, the rate of smooth intubation (navigability) was high in both groups of our study. The relatively high incidence of persistent epistaxis (9.8%) reported in the control group in comparison with 0% in the study group supported our conclusion regarding the efficacy of xylometazoline in reducing epistaxis. According to the suggestions given by the peer reviewers and the section-editor, we have done some reductions in the manuscript before publishing it, we removed the description of the method of identifying the patent nostril which was based on the history from parents and preoperative examination by the airway patency test, where estimation of the rate of airflow through each nostril during expiration by palpating the passage of air when the contralateral nostril was occluded. Right nostril was chosen if patency appears equal in both sides of the nose, which is also more convenient for the right-handed

4 Smith JE, Reid AP. Asymptomatic intranasal abnormalities influencing the choice of nostril for nasotracheal intubation. Br J Anaesth 1999; 83: 882–6

3 Tong JL. Smaller is better through the nose. Anesth Analg 2008; 106: 1925
4 Tong JL. Smaller is better through the nose. Anesth Analg 2008; 106: 1925