CORRESPONDENCE

AN AIRWAY FOR DIRECT COUPLING TO THE ANAESTHETIC CIRCUIT

Sir,—More day cases are being done under general anaesthesia than in the past. Many of these patients have lesions on their noses and around their mouths, which are covered by the anaesthetic facepiece. This necessitates either "snatch surgery" or intubation under succinylcholine, which is a disadvantage to the patient, bearing in mind the high incidence of muscle pain in the ambulant patient.

I have managed these cases by utilizing a modified airway which can be connected directly to the catheter mount of the anaesthetic circuit. The airway is inserted after the usual induction and settlement on halothane with a facepiece, and the anaesthetist merely supports the jaw. The duration of anaesthesia is entirely in his hands.

There are other uses, which I am sure each anaesthetist will adapt to his own particular needs. Figure 1 shows the airway in place and demonstrates that the whole face is accessible to surgery, wherever the lesion may be. The airway (fig. 2) is of the plastic Guedel type and has a female Nosworthy mount fused to it. It is available in three sizes.

I am indebted to Portex Limited for manufacturing these for me.

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FIG. 1

FIG. 2

HICCUP DURING ANAESTHESIA:
A CLINICAL OBSERVATION

Sir,—It has been our experience that patients anaesthetized for minor gynaecological operations frequently develop hiccup soon after induction of anaesthesia but prior to the commencement of surgical manipulations.

The causes of hiccup seen during anaesthesia are believed to be too light a plane of anaesthesia, nervousness of the patient (high reflex irritability), stimulation of the vagal nerve endings (e.g. during gastrectomy) and a raised blood carbon dioxide content (Lee and Atkinson, 1968). Only the first two factors could have been operative during the minor surgery which our patients underwent. All patients were anaesthetized with thiopentone and gallamine 20 mg for induction followed by N2O, 02 and trichloroethylene or halothane.

The agents used did not affect the incidence of hiccups. It was felt that inadequate depth of anaesthesia could not have been operative as the hiccups were noticed to occur before surgery commenced, ruling out the possibility of a reflex due to too light a plane of anaesthesia. If nervousness of the patient was responsible there was no reason why only this particular category of patients should develop hiccup.

The only factor that was common to these patients and distinguished them from other patients was that they were positioned on the operating table after the induction of anaesthesia. Positioning involved the patient’s being moved down the table and then being placed in lithotomy position. The positioning was done whilst the facepiece was being held in position. It was felt that shifting the patient down the table while the neck was kept extended due to the application of the facepiece may have been responsible for the initiation of the hiccup.

To test this hypothesis it was decided to induce anaesthesia with the patient positioned in such a manner that it was not necessary to move the patient down the table after induction of anaesthesia. Since using this modification of technique no patient has developed hiccup during anaesthesia.

A possible explanation for this observation could be that moving the patient down the table whilst the neck was kept extended by holding the facepiece in place irritated the phrenic nerve by stretching as the roots emerge from the intravertebral foramina.

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REFERENCE

SIMPLE AND RELIABLE METHOD OF INSERTING A NASOGASTRIC TUBE DURING ANAESTHESIA

Sir,—In the June number (Brit. J. Anaesth., 44, 610), Matsuki and Zsigmond described a most unusual method for the insertion of the nasogastric tube during anaesthesia, using a "guitar E string". Since the guitar is not an instrument which is normally used in anaesthesia, most anaesthetists will be unaware that there are two E strings — the first and the sixth strings. The first string is the highest pitched on the instrument and is made of thin gut, nylon or steel. The sixth string may also be made of any of these materials but is invariably wire-bound and is much thicker, being the bass string of the instrument. Presumably the string which is recommended for the insertion of a nasogastric tube is the thicker bass E string.

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