revealed a tumour in the small bowel mesentery with adherent loops of small bowel, which on histological examination was found to be lymphoma. The stomach, duodenum and jejunum were dilated. The lungs showed signs consistent with adult respiratory distress syndrome.

This case reinforces the importance of systematic preoperative assessment as previously advocated,\(^1\) bearing in mind the possibility of systemic involvement from disease processes. Despite the resolution of gastrointestinal symptoms, our patient was still at risk of aspiration.

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**CEMACH report: oesophageal intubation**

Editor—We read with interest Piepho and colleagues’ description of a traumatic nasotracheal intubation (NTI) in a patient with an unanticipated difficult airway.\(^1\) We would like to suggest an addendum to Piepho’s algorithm for NTI.

Any algorithm for NTI should include anticipated difficult airways. We feel this is pertinent as the nasal route is often used in cases with inadequate mouth opening and for oral and maxillofacial surgery. We have previously described the airway management with NTI in patients with anticipated difficult airways.\(^2\)

In the ‘NTI in anticipated difficult airway’ algorithm, we too like to look before we leap! First, we assess the airway under anaesthesia. When NTI is used for potentially difficult airways, it is important to maintain spontaneous ventilation.\(^3\) A preliminary laryngoscopic view under anaesthesia is useful for patients with adequate mouth opening.\(^4\) In Piepho’s algorithm, ‘direct laryngoscopy’ could be renamed ‘preliminary laryngoscopy’. If the view is Cormack–Lehane (CL) 1 or 2, the plane of anaesthesia is further deepened using i.v. or volatile anaesthetic agents. Intubating laryngoscopy and tracheal intubation follows. NTI has been successfully performed without neuromuscular blockade.\(^5\) If the view is CL 3 or 4 or if laryngoscopy cannot be performed, the alternatives suggested by Piepho can be adopted.

The nasal cavity evaluation can also be carried out under anaesthesia; best immediately after the preliminary laryngoscopy. The apparently more patent nostril would have been already selected preoperatively by the airway patent test\(^6\) and suitable vasoconstrictors applied. If the nasal passage seems unsuitable for tracheal tube passage then the oral route or submental route may be used. Smith and Reid\(^7\) found a high incidence of intranasal pathologies (68% of their patients) that would make nasotracheal intubation difficult and have suggested fiberoptic intubation to select the best nostril. However, they add that despite major abnormalities, these patients do not sustain serious injury more frequently during intubation. We agree with their opinion that with experience, anaesthetists develop an acute sense of how much pressure they can apply on the tracheal tube before they abandon it for the other nostril.

Because of bleeding, Piepho and colleagues found themselves dealing with a dangerously difficult airway,\(^7\) possibly because they attempted NTI in a single step. Successful nasotracheal intubation, as described in their and other\(^8\) algorithms, consists of three important steps—adequate laryngoscopic views,atraumatic nasopharyngeal intubation, and passage of the tube into the trachea.

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**Nasotracheal intubation**

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Any algorithm for NTI should include anticipated difficult airways. We feel this is pertinent as the nasal route is often used in cases with inadequate mouth opening and for oral and maxillofacial surgery. We have previously described the airway management with NTI in patients with anticipated difficult airways.\(^2\)

In the ‘NTI in anticipated difficult airway’ algorithm, we too like to look before we leap! First, we assess the airway under anaesthesia. When NTI is used for potentially difficult airways, it is important to maintain spontaneous ventilation.\(^3\) A preliminary laryngoscopic view under anaesthesia is useful for patients with adequate mouth opening.\(^4\) In Piepho’s algorithm, ‘direct laryngoscopy’ could be renamed ‘preliminary laryngoscopy’. If the view is Cormack–Lehane (CL) 1 or 2, the plane of anaesthesia is further deepened using i.v. or volatile anaesthetic agents. Intubating laryngoscopy and tracheal intubation follows. NTI has been successfully performed without neuromuscular blockade.\(^5\) If the view is CL 3 or 4 or if laryngoscopy cannot be performed, the alternatives suggested by Piepho can be adopted.

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