Correspondence

**Imaging of the axillary vein**

Editor—In figure 3a of the recent article on imaging of the axillary vein,1 from a radiological point of view and according to line A in figure 2, the bright structure that you named rib cage may be either rib cage or lung pleural interface. You can differentiate between them by their posterior shadowing as the rib cage has dark shadow and the lung pleural interface has a bright layering shadow with linear comet tail artifacts and as you cannot ask the patient to catch his breath you may see both of them alternately so the posterior shadowing is important. The lung pleural interface carries the risk of pneumothorax if penetrated by the needle then the vein in line C is safer for puncture than line A and B C.

M. M. Gabal  
*E-mail: hindoma@yahoo.com*

This letter was originally submitted as an E-letter.


doi:10.1093/bja/ael198

**Morphine-induced pruritus after spinal anaesthesia**

Editor—I read with interest the study by Horta and colleagues1 in which they compared the prophylactic effect of droperidol, alizapride, propofol and promethazine on spinal morphine-induced pruritus. *Br J Anaesth* 2006; 96: 796–800

Borgeat A, Stirnemann HR. Ondansetron is effective to treat spinal or epidural morphine-induced pruritus. *Anesthesiology* 1999; 90: 432–6


doi:10.1093/bja/ael199

**Uvula necrosis—an unusual cause of severe postoperative sore throat**

Editor—We would like to present a case of uvula necrosis after an otherwise uneventful intubation and anaesthetic. A 38-yr-old woman presented for an abdominoplasty. She had no significant past medical history, was a non-smoker and there was no history of recent upper respiratory tract infection. Intubation of the trachea was straightforward with a grade 1 view using a Mackintosh blade and a size 7.5 cuffed tracheal tube. The anaesthetic and extubation were uneventful and blind suctioning was not performed. In the recovery room she complained of a sore throat.
She was reassured that this was not uncommon and that the regular analgesia prescribed would help. However, on the following day she was reviewed and although her abdomen was comfortable her throat was still extremely painful, to the extent that she was unable to swallow easily, unable to eat or drink and had the sensation of a foreign body in her throat. On inspection of her pharynx an elongated, swollen and dusky uvula was noted with a clear demarcation line (Fig. 1). She was reviewed the same day by an ENT consultant and the assumption was made that the uvula had suffered some trauma from impingement of the tracheal tube, which is a rare but not unreported complication of tracheal intubation.\(^1\) She was treated conservatively with analgesia and antibiotics and warned that the tip of the uvula would probably necrose and separate. Her discomfort persisted for 5 days but she made a complete recovery.

Sore throat after tracheal intubation is a common event with an incidence between 24 and 100%.\(^2\) A recent prospective evaluation of 809 patients found it to occur in 40% with an average duration of 16 ± 11 h.\(^3\) However, a very severe or persistent sore throat is much rarer and in these cases uvula necrosis should be part of the differential diagnosis. It can cause significant postoperative morbidity and we suggest that all patients who complain of a non-resolving sore throat after tracheal intubation, particularly if associated with a foreign body sensation or difficulty swallowing, should have their oropharynx examined carefully.

Uvular necrosis is felt to be secondary to a mechanical interruption of the blood supply to the uvula. It has been reported after tracheal intubation with a long tracheal tube placed in the midline causing excessive compression of a long uvula between the hard palate or an oral airway, blind pharyngeal suctioning with a hard plastic sucker\(^1\) and upper GI endoscopy.\(^4\) The simple precaution of positioning the tracheal tube to one side of the midline might help avoid this complication.

Treatment options reported in the literature include i.v. steroids, antihistamines, antibiotics and topical adrenaline administration.\(^5\) However, even if no treatment is required, it is important to be able to explain the condition to the patient, as it can be extremely distressing, and provide reassurance that symptoms should resolve within a few days to weeks and offer follow up.

C. J. Atkinson*  
J. Rangasami  
Slough, UK  
*E-mail: atkinsoncatherine@hotmail.com

---

1 Harris MA, Kumar M. A rare complication of endotracheal intubation. Lancet 1997; 350: 1820–1

doi:10.1093/bja/ael200