airways, which has important implications in the clinical setting especially in paediatric practice.

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References

1 Moore S, Glaisyer H. Unusually shaped Guedel airways. *Anaesthesia* 2005; **60**: 723–4.
2 Anonymous. *The Medical Devices Regulations 2002*. London: The Stationery Office Limited, 2002.
3 Medicines and Healthcare products Regulatory Agency. *Directives Bulletin no. 8: Information about the EC Medical Devices Directives*. London: MHRA, 2002.
4 Medicines and Healthcare products Regulatory Agency. *Directives Bulletin no. 13: Standards*. London: MHRA, 1994.

Supplementary oxygen during Caesarean section

We read with interest the recent letter of Edsell and Erasmus [1]. Our original paper [2] was the first national survey of practices relating to the use of the common gas outlet for administration of supplementary oxygen during Caesarean section under regional anaesthesia. The principle aim of this survey was to highlight the potential risks of the practice of disconnecting the standard anaesthetic circuit from the common gas outlet in order to use the common gas outlet to deliver supplemental oxygen for a procedure conducted under regional anaesthesia. This practice exposes the patient to two potentially unnecessary risks. The first is that of using a circuit which has been disconnected from the common gas outlet and not subsequently reconnected, and the second, the inadvertent administration of volatile anaesthetic agent to a patient having a procedure conducted under regional anaesthesia.

Whilst the safety precaution of attaching the proximal end of the breathing system (the fresh gas flow connection) to the distal end of the circuit, as advocated by Edsell and Erasmus, may make the first scenario less likely, it relies on every user to remember to do this every time the circuit is disconnected, and so does not totally eliminate the risk of it occurring. Furthermore, by persisting with the use of the common gas outlet, their precaution does nothing to reduce the potential risk of inadvertent volatile anaesthetic admission. The most recently published Confidential Enquiry into Maternal and Child Health (CEMACH) report [3] recommends a separate oxygen supply should be used for the delivery of supplementary oxygen during regional anaesthesia. This follows the sad and potentially avoidable death of a mother in which a disconnected breathing circuit was at least partly implicated. Our original article [2] was inspired by a critical incident in our own hospital involving a disconnected breathing circuit, and concluded with a similar recommendation.

There cannot now be any doubt that the practice of using the common gas outlet for the administration of supplemental oxygen to patients undergoing procedures under regional anaesthesia is fraught with potential for disaster. The solution is very simple and recommendations have been made. Supplemental oxygen for procedures conducted under regional anaesthesia must be administered from a dedicated source separate from the common gas outlet and standard anaesthetic breathing circuit. The practice of using the common gas outlet for this purpose should cease immediately. Units that do not have anaesthetic machines with a separate oxygen source should either upgrade their machines or provide a free-standing oxygen cylinder. We believe a statement to this effect from the Royal College of Anaesthetists and the Association of Anaesthetists could help protect all concerned from further tragedy.

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References

1 Edsell MEG, Erasmus PD. Use of the common gas outlet for supplementary oxygen during Caesarean section. *Anaesthesia* 2005; **60**: 1152.
2 Stone AGH, Howell PR. Use of the common gas outlet for the administration of supplementary oxygen during Caesarean section under regional anaesthesia. *Anaesthesia* 2002; **57**: 690–2.
3 Confidential Enquiry into Maternal and Child Health. *Why Mothers Die 2000–02. The sixth report of the Confidential Enquiry into Maternal Death in the United Kingdom*. London: RCOG Press, 2004.

The Seeing Optical Stylet™ for percutaneous tracheostomy

A recent postal survey showed that 83% of ICUs routinely use bronchoscopy throughout percutaneous tracheostomy to ensure correct tracheal placement of needle, guide wire, dilator and the final insertion of the tracheostomy tube [1]. Direct vision during the procedure may reduce the incidence of low entry into the trachea, and also prevent iatrogenic damage to the posterior tracheal wall. Bronchoscopes are now widely available, but are expensive to buy and easily damaged. They may also be 'out of action' because of servicing or cleaning. Damage to bronchoscopes has been reported during percutaneous tracheostomies from the needle used to insert the wire [2].

We performed a percutaneous tracheostomy with endoscopic confirmation using the Seeing Optical Stylet™ (Clarus Medical Systems, Minneapolis, MN); a high resolution (30 000 pixel) endoscope (Fig. 2). It has a malleable stainless-steel sheath that can easily be shaped to pass down the tracheal tube so that the procedure can be visualised.

We can think of a number of advantages in using this kind of device for percutaneous tracheostomies in the ICU. Firstly, it is cheaper to purchase and maintain. Secondly, it may be less prone to getting damaged from the needle used to insert the wire. Thirdly, in our experience, it is very easy to use, requiring only a brief learning period.

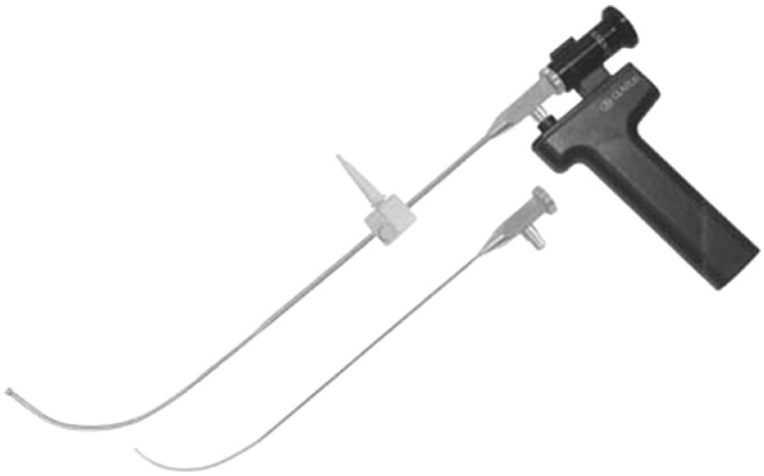

Figure 2 The Seeing Optical Stylet™.

Finally, it is easy to clean, and the 'turn around time' before it can be used again may be quicker. The possible disadvantages of using the Seeing Optical Stylet rather than a bronchoscope are that it does not have a suction port, and secretions and blood cannot be directly aspirated. It may also take slightly longer to obtain an optimal view of the procedure, as the malleable sheath may need manual adjustments for which it has to be withdrawn from the tracheal tube. Lastly, it is clearly not possible to proceed to a bronchoscopy if that is indicated.

The Seeing Optical Stylet is unlikely to replace the bronchoscope in percutaneous tracheostomies. However, it may be used as an alternative, and have wider applications in the intensive care setting.

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References

1 Krishnan K, Elliot SC, Mallick A. The current practice of tracheostomy in the United Kingdom: a postal survey. *Anaesthesia* 2005; **60**: 360–4.
2 Juste RN, Dakin M, Soni N. Percutaneous tracheostomy: an expensive complication. *Anaesthesia* 1997; **52**: 711–2.

Difficulty with flanged tracheostomy tubes

Failure to deflate the cuff due to kinking of the pilot tube with the flange at its take-off from the tracheostomy tube reported by Barker and Prasad [1] is similar to the well-known kinking of the pilot tube at the take-off point with a tie around tracheal tubes [2, 3]. Invariably all the problems related to the pilot tube that can lead to the inability to deflate the cuff occur due to kinking or obstruction at the take-off point. In spite of the instructions on the product information produced by manufacturing companies, such incidents will continue to happen, as the instructions for use are rarely read. What is needed is some mechanism by which the possibility of obstruction is eliminated altogether, such as placing a stop distal to the take-off point so that the flange can be prevented from rotation or coming close to this point and leading to kinking.

If the pilot tube is obstructed due to any cause and the cuff can not be deflated, the intramural inflating channel in the wall of the tracheal tube can be opened to the atmosphere by placing a full depth cut on the wall across the channel distal to the take-off point of the pilot tube [4]. This allows the air in the cuff to escape, preventing the risk of trauma if the tube is removed with the cuff inflated. Cutting open the intramural channel is a safer option than other methods of deflating the cuff such as puncturing it directly or percutaneously with a needle.

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References

1 Barker JM, Prasad K. Difficulty with a flanged tracheostomy tube. *Anaesthesia* 2005; **60**: 939.
2 Allen JS, Webb ST. Tied up in knots. *Anaesthesia* 2004; **59**: 515.
3 Bhanumurty S, McCaughy W, Graham JL. Deflated tracheal tube cuff with inflated pilot balloon. *Anaesthesia* 1993; **48**: 1109–10.
4 Singh B, Gupta R, Singla SL. Difficult extubation: a new management. *Anesthesia and Analgesia* 1995; **81**: 433.

Dexmedetomidine for peri-operative sedation and analgesia in alcohol addiction

I report on the use of dexmedetomidine for peri-operative analgesia and sedation prophylaxis of alcohol withdrawal syndrome in two alcoholic patients.

A 60-year-old man presented for laparoscopic nephrectomy. His medical history included hypertension, anxiety neurosis, emphysema, smoking and alcoholism. He was anxious, with a heart rate of 107 beats.min^{-1} and blood pressure of 159/97 mmHg. Intravenous dexmedetomidine infusion was commenced with a loading dose of 1 μg.kg^{-1} over 15 min, followed by a continuous infusion of 0.5–0.7 μg.kg^{-1}.h^{-1}. He was adequately sedated, and maintained verbal communication. Anaesthesia was induced with fentanyl 100 μg and propofol 200 mg, and maintained using isoflurane and dexmedetomidine infusion, with vecuronium for muscle paralysis. At completion of surgery, the isoflurane was stopped and residual neuromuscular blockade reversed. With the patient obeying commands and breathing adequately, the dexmedetomidine was discontinued and he was extubated. The intra-operative course and emergence were smooth. Postoperatively, he