

Answer To Letter To The Editor: Mishaps With Endotracheal Tube Exchangers In ICU: Two Case Reports And Review Of The Literature

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Citation

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Abstract

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Dear Sir:

We would like to thank Dr. Mort for his lengthy insight about his personal experiences with the use of airway exchange catheters (AEC), sharing information from the database of his institution, and his comments on our paper (1). Also, we would like to thank the Editor for allowing such extensive letter to be published despite the traditional restrictions to five hundred words (2, 3); it demonstrates the commitment of the journal to educate and as an edge source of medical information on the Internet (4).

A few issues in the letter need clarification. First of all, despite Dr. Mort's assertions that we did not specify what was the type of damage of the ETT, we certainly stated what part of the endotracheal tube (ETT) was damaged in the first sentence of the first case "...due to the rupture of the ETT cuff port at its origin", making the commentaries on this subject informative but unnecessary. The ETT cuff was inflated after removal connecting a needle to the remaining shortened portion of the cuff port left under the plaster supporting the ETT in place before the exchange. Secondly, we said in our introduction "Endotracheal tube exchangers (ETTE) or airway exchange catheters (AEC) have been reported to be easy and safe to use". We added in the discussion "ETT exchange is a simple procedure, and it does not seem to require especial training. However...". Finally, we added "Endotracheal exchangers should be handled with caution; the rate of failure seems to be higher than expected depending..." etc. Our opening statement, or our comments

in the discussion in no way contradict our conclusions. We chose our words carefully and tried to keep our statements short, simple and as unbiased as possible. We believe this procedure is indeed simple but dangerous. Third, the cases reported were patients with uncomplicated airways, in which we took advantage of the opportunity to teach inexperienced residents how to use AECs, in a fully controlled setting, stable patients, enough personnel and equipment (including and airway chart with fiberoptic bronchoscope, Esophageal Tracheal Combitube®, etc.), under direct supervision of the ICU attending and team that knew the patients for days. Due to publication restrictions in this type of paper, we opted not to include these details. We certainly agree with Dr. Mort in the value of the airway exam with a laryngoscope and teach it to our residents, but such survey was not indicated in these cases. Fourth, regarding to the comments on the paper by Loudermilk et al. (5), the reason this study was included is that while it is true that they used the catheters for extubation the authors' objective was to use the catheters as a guide for reintubation in case it becomes necessary in a population of difficult airway patients.

Finally, we are very happy to see that our report is achieving the most important of our goals when we wrote it, to increase awareness and elicit discussion about the incidence of mishaps and other dangers during endotracheal tube exchanges. We hope our readers learn from Dr. Mort and our experiences.

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