An uncommon cause of intraoperative airleak

Sir,

An airleak around endotracheal tube (ETT) may make maintenance of adequate ventilation difficult and it may lead to aspiration. We encountered a case wherein malpositioned nasogastric tube (NGT) caused airleak around the ETT.

A 45-year-old man was brought with foreign body impalement of the face and cervical spine. Transoral exploration and disimpaction of iron rod (in supine posture) and posterior fixation (in prone posture) of occiput (C2-C3 with screw and rod fixation) was planned. Awake fiberoptic bronchoscopy (FOB)-assisted orotracheal intubation was done with flexometallic ETT. There was no airleak around the ETT and this was confirmed with end tidal CO$_2$ monitor and pressure volume loop graphs. After removal of iron rod by transoral approach, NGT tube was inserted by the surgeon. Soon thereafter, airleak appeared on pressure volume graph along with audible leak. Seeking a cause for airleak, the pilot balloon of flexometallic tube was checked and was found to be intact. Air entry was bilaterally equal. Breathing circuit and ventilator were examined but no abnormality was identified. FOB was again performed to rule out ETT displacement. It was noticed that NGT, which was inserted at the end of the first part of the surgery, entered into the trachea alongside the intact cuff, reaching up to the carina [Figures 1]. The NGT was pulled out and the airleak resolved.

The insertion of NGT is a common procedure in anaesthesia and intensive care setting. Unnoticed
Concurrent infection of dengue fever and hepatitis A infection: A case report

Sir,

Both dengue fever and hepatitis A infection are endemic in developing countries and are associated with poor sanitation and low socioeconomic status. Their coexistence can present a diagnostic dilemma to the treating physician.

A four-year-old girl was admitted with high-grade fever, vomiting, and abdominal pain for 7 days and jaundice for 3 days. On admission she was conscious and hemodynamically stable. Deep icterus was present. The liver was tender with a span of 10 cm and the spleen palpable 2 cm. Other systems were normal. The differential diagnoses considered were malaria, typhoid fever, dengue fever, and leptospirosis. Investigations revealed: hemoglobin 14.8 gm/dL, total leukocyte count 6200/mm$^3$, and platelet count 59,000/mm$^3$. Peripheral blood smear was negative for malarial parasite. Serum electrolytes, blood culture, urine culture, renal function tests, serum calcium were normal. Widal test and leptospirosis serology were negative. Polymerase chain

Commonly accepted clinical signs for proper NGT placement are auscultation, fluid aspiration, absence of coughing and visual inspection of gastric aspirate. Bubbling sounds may be absent, especially in air-filled stomachs or are heard in the epigastrium while tubes are localized intrapulmonary or in the pleural space. In most cases of tracheal malpositions, NGTs were considered to be properly placed by auscultation.

To conclude, low pressure inflated endotracheal cuff may not completely secure the airway and NGT can still negotiate alongside it causing airleak. We may suspect malpositioned NGT if an airleak occurs immediately after NGT insertion. FOB does increase the sensitivity to identify source of airleak and confirm malpositioned NGT.

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References