Cardiopulmonary resuscitation in a tertiary care hospital” by Sodhi et al. with interest.[1] In the current scenario of improving the rescue rate following major events including cardiac arrests, as often called “lower failure to rescue rate,” advanced training and recertification in life support programs such as advanced cardiac life support (ACLS) and neonatal life support (NLS) are extremely vital and important. Nothing can replace their role in achieving higher rescue in such a scenario, and I should congratulate the author for highlighting this point again by a very useful assessment. But, I tend to raise some queries in their audit method. While I am not surprised to find that prior training helps in improved rate of successful return of activity and hospital discharge following arrests, one wonders if the case mix between the groups is comparable at all to come to any meaningful conclusion in this regard. Although the demographic data may not have shown any gross difference between the groups, the reason leading to cardiac arrest is never assessed and, hence, the difference between the groups is not known, as to whether it is due to a real impact by training or a spurious association secondary to change in disease profile. Differences in the duration of resuscitation though may have a secondary impact on the ability of the organs to recover from cardiac arrest, while lots of other factors play more important roles in this, such as primary disease causing cardiac arrest, multiorgan dysfunction and whether the arrest itself was primary or following multiple prearrests before the actual event. It is not surprising to find support in such thinking, as was shown by Olasveengen, with a weak trend in improved discharge rate following cardiac arrest.[2]

Moreover, the program should involve regular and periodic recertification, and focus should be on updating to most recent guidelines. Focus should also be given to regional variation in aspects of diseases leading commonly to arrest scenario, and ability to recognize a near-arrest should be given equal importance. External life support in the form of extra-corporeal membrane oxygenation (ECMO) as an assist to cardiopulmonary resuscitation (e-CPR) is coming into use more often in developed countries, especially in children.[3]

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We read with interest the letter to editor by Soni et al. [1] in the October – December 2011 issue, on the problem of air leak around endotracheal tube due to malposition of nasogastric tube (NGT) in the trachea. As an intensive care physician, we routinely place gastric tube via oral or nasal route blindly in ventilated or non-ventilated patients. It is common for the nasogastric or orogastric tube (NGT/OGT) to slide in the trachea, also by the side of endotracheal or tracheostomy tube.

Malpositioning of NGT/OGT feeding tube in the trachea results in devastating complications, which are usually preventable.

As NGT/OGT tube insertion is a routine procedure in ICUs, operation theatres, wards and emergency area, it does not seem practical to check for NGT/OGT position with fiberoptic bronchoscopy in all the patients.

We are using a simple 4-step method for a long time now to prevent this avoidable complication:

• Insert NGT/OGT with recommended method.
• Check by auscultation of air insufflation with 20 ml syringe in the epigastrium.
• Keep the proximal end open for one minute to allow injected air to come out.
• Bring the proximal end of NGT/OGT close to the cheek and feel for the movement of air [Figure 1].

In spontaneously breathing patient movement of air will be felt on the cheek during expiration while in patients on mechanical ventilation or non-invasive ventilation continuous flow of air is felt on cheek.

We always follow these simple steps while inserting NGT/OGT blindly, thereby avoiding the most devastating complications in a simple way. Moreover, if this final step is not fulfilled then we remove and reposition the NGT/OGT. Since, this is an usual practice in our department we have rarely encountered any complication or ventilator malfunction in our ICUs and wards during insertion of NGT/OGT.

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