PostScript

LETTERS

Intracranial placement of a nasopharyngeal airway in a gun shot victim

Further to the review by Roberts *et al*¹ and the letter by Ellis *et al*,² we report another case of intracranial placement of a nasopharyngeal airway.

The patient was an adult who had been shot in the head and dumped by the roadside in Baghdad in 2006. The patient was found by a military patrol who gave first aid. The medic on scene noted that the patient was deeply unconscious, had facial injuries and an obstructed airway. A nasopharyngeal airway was placed and rapid transfer undertaken to the US combat support hospital (CSH) in the international zone.

At the CSH, the patient underwent resuscitation (including endotracheal intubation) and a CT scan to confirm the extent of injuries. The CT scan demonstrated the path of the bullet through the frontal region of the casualty's head, damage to the cribriform plate and intracranial placement of the nasopharyngeal airway. The patient later died from the injuries.

The emergency medicine consultant commented that, on initial examination, the facial trauma was easy to miss and the mid-face was structurally stable. The extent of the injury would have been difficult to assess in the field.

An internet search for intracranial placement of nasopharyngeal airways produced the reports by Muzzi *et al*³ and Schade *et al*⁴ (as referenced by Roberts¹) and an additional case report by Martin *et al*.⁵

The report by Martin *et al* describes a patient with severe craniofacial trauma from a motorcycle accident, who had bilateral nasopharyngeal airways sited by the prehospital provider, one of which was placed intracranially.

Martin *et al* state that airway management in these patients is problematic and, where orotracheal intubation is not practical or possible, the standard of care for airway management is a surgical airway. They recommend the oropharyngeal airway as the non-invasive airway of choice and that nasopharyngeal airways should be avoided as they have the potential for worsening intracranial injury.

During our time in Baghdad we regularly cared for patients with blunt and penetrating head injury, and the patient we describe is the only case of intracranial nasopharyngeal airway placement we came across.

We still recommend its use for military prehospital providers.

Prehospital care in a high-threat or potentially high-threat environment has to be about compromises. Current UK Battlefield Advanced Trauma and Life Support teaching⁶ builds on the work of Butler *et al*⁷ and teaches that clinical care has to be modified according to the threat environment (Battlefield Advanced Trauma and Life Support (BATLS) is the UK military derivation of Advanced Trauma and Life Support).

The nasopharyngeal airway can be rapidly placed in a casualty and usually stays in place when the casualty is moved to a lower threat area.

We agree that, when the situation allows, the airway should be placed carefully as described by Roberts.¹

David Steinbruner

Evans Army Community Hospital, Fort Carson, Colorado, USA

Robert Mazur

Winn Army Community Hospital, Fort Stewart, Georgia, USA

Peter F Mahoney

Royal Centre for Defence Medicine, Birmingham, UK

Correspondence to: Dr P F Mahoney, Royal Centre for Defence Medicine, ADMEM RCDM Institute of Research and Development, Birmingham Research Park, Vincent Drive, Edgbaston, Birmingham B15 2SQ, UK; SenLeeCC.ADMEM@rcdm.bham.ac.uk

doi: 10.1136/emj.2007.046490

Accepted 15 January 2007

Competing interests: PFM is one of the authors of the UK Battlefield Advanced Trauma and Life Support (BATLS) course and instructs on the course.

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Counting angels

The question "how many angels can dance on the head of a pin?" is sometimes used as a rhetorical illustration of the futility of meaningless or esoteric debate, and in the paper by Clements *et al*,¹ which discusses whether children in the prehospital environment should be treated with a cuffed or uncuffed tracheal tube, the authors come quite close to trying to count those angels.

Contrary to the image conjured up of teams of paediatric airway specialists poised to descend on sick children in the community, the reality is somewhat different. The vast majority of children will be treated by paramedics and ambulance technicians—sometimes assisted by volunteer immediate care physicians or general practitioners—very few of whom are likely to possess that rare combination of skill, equipment and drugs necessary to intubate children outside hospital in reasonable safety.

Most seasoned emergency physicians will have seen cases of unrecognised tracheal tube

misplacement in prehospital care, and it is partly in recognition of the disaster that accompanies such events that the Joint Royal Colleges Ambulance Liaison Committee has recently signalled that it wants to readdress the value of the tracheal tube in paramedic practice.² Yet, there are still those diehards within the UK's ambulance services who cling to the notion that the tracheal tube is the gold standard of prehospital airway management, despite compelling evidence to the contrary.^{3,4} The increasing availability of affordable, portable, electronic capnometers goes only part of the way to addressing the overall problem, since these will not prevent those unnecessary periods of intensified hypoxaemia that accompany repeated failed attempts at intubation. We need to keep reminding ourselves that patients die from a failure to oxygenate and a failure to ventilate, not from a failure to intubate, and there is now a growing view that supraglottic airway devices are better and safer options in the hands of non-anaesthetists who work in the prehospital environment. It could even be that supraglottic airway devices are superior to the tracheal tube in the hands of those few skilled anaesthetists who do venture out into the community, but I can find no evidence that a comparative trial has ever been undertaken to test this hypothesis.

Clements *et al* are right in saying that we should always be ready to challenge doctrine, but I would suggest that the doctrine that most needs to be challenged is the one that confers gold standard status on the tracheal tube in prehospital care. If the trend away from intubation continues, the question as to whether a child's tracheal tube should be cuffed or uncuffed could soon become irrelevant for the vast majority of prehospital providers.

Andrew M Mason

Correspondence to: Dr A M Mason, Suffolk Accident Rescue Service, The Old Rectory Church Lane, Norton, Bury St Edmunds IP31 3NB, UK; amason@tesco.net

doi: 10.1136/emj.2007.046540

Accepted 16 January 2007

Competing interests: AMM is clinical adviser to The Laryngeal Mask Company, St Helier, Jersey, Channel Islands, UK, and also to Intavent Orthofix, Maidenhead, UK, and a distributor of LMA devices in the UK and Eire. Both are unsalaried positions, but the author has received payment for advisory work undertaken for both companies in connection with the use of LMA devices in prehospital care.

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