Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Stomal Embellishment following Tracheostomy for Obstructive Sleep-Related Apnea

To the Editor:

In some patients with the syndrome of sleep-related apnea, the cardiovascular complications and social problems are significant. If these patients are observed to have obstruction of the upper airway at night, tracheostomy will bypass the obstruction, relieve the apneic episodes, and restore the patient to some measure of normal function.

Since this involves a permanent tracheostomy, there are social and psychologic factors to consider, in addition to the surgical complications of the procedure. Explanations of the details of the surgery and the cosmetic effects are necessary to help the patient adjust to the prospect of living with a tracheostomy.

Contact with a previously tracheostomized patient who has successfully adjusted is also helpful. A major concern is the stares and questions of the uninformed, which make the patient uncomfortable and self-conscious. Following the usual attempts at camouflage (scarves, acots, etc), one of our patients arrived at the solution shown in Figure 1. Since it is socially acceptable nowadays for men to wear medallions (Fig 2), neck chains, and other types of embellishment, the patient’s appearance now attracts little attention.

After tracheostomy, this patient’s complaints of daytime hypersonomolence and his nocturnal abnormalities have subsided. To date, he has lost over 18 kg (40 lb) in body weight, has improved his exercise tolerance, and enjoys an improved quality of life. His ingenuity in adapting to his disease and its treatment should be encouraging to other patients with syndromes of sleep-related apnea and to the physicians who care for them.

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The Esophageal Obturator Airway

To the Editor:

The report by Bryson and associates1 on the esophageal obturator airway has prompted us to review its role in cardiopulmonary resuscitation. We believe their work is conceptually and technically flawed and leaves the erroneous impression that the esophageal obturator airway is a useless device.

A decade ago, the esophageal obturator airway was introduced to fill the pressing need for a device that required less training than endotracheal intubation, would secure a patent airway rapidly and safely, would isolate the airway from the dangers of gastric distention and regurgitation, and would be compatible with other adjuncts to the airway. Today the esophageal obturator airway is widely accepted and used throughout the United States and elsewhere because it has been proven to fill this role effectively. Based on our controlled experimental studies and extensive clinical experiences since 1970,2-3 and on the reported studies of others,4-8 we would like to address the problems with the experimental design of the report by Bryson et al1 and its criticisms of the esophageal obturator airway.

1. Contrary to statements made in the report by Bryson et al1, substantial experience in the field by us and others attests to the ease of insertion of the esophageal obturator airway if the tube is well lubricated and if the patient’s head and airway are properly positioned. The esophageal obturator airway should be used only for apneic, areflexic unconscious patients; however, in the study by Bryson et al1, the subjects did not receive muscular relaxants and did not mimic the true