Although the esophageal obturator airway and esophageal gastric tube airway have some drawbacks, their place in care before hospitalization has been firmly established.

Richard J. Melker, M.D., Ph.D. 
Department of Pediatrics (Cardiology) 
University of Florida College of Medicine, Gainesville 
and Archer S. Gordon, M.D., Ph.D. 
Research Physiologist, Department of Anesthesiology 
Center for the Health Sciences 
University of California, Los Angeles

REFERENCES


3. Gordon AS: Clinical experiences with the esophageal obturator airway (EOA) and esophageal gastric tube airway (EGTA). Read before the Third Annual UCLA Postgraduate Institute in Emergency Medicine, Los Angeles, Jan 30-Feb 3, 1978


To the Editor:

We think the "controlled experimental studies and extensive clinical experiences since 1970" of Melker and Gordon do not provide a basis for either the rational use of the esophageal obturator airway or criticism of our report. Reference 2 is an invited report given at a medical conference. Reference 3 is an invited lecture delivered at a medical meeting. Reference 4 is an invited article in a symposium on instrumentation for emergency medical care. Reference 5 is in a journal that is not listed in Index Medicus. None of these four references have undergone peer review or examination by expert referees.

Reference 5 attempted to compare arterial blood gas levels determined during use of the esophageal obturator airway to blood gas levels obtained in the same patient while an endotracheal tube was in place. Although the data are of empirical interest, the comparison is invalid without measurement of minute ventilation; however, with the possible exception of our case, our data are compatible with those in reference 5.

Reference 8 reported two cases of esophageal tears following use of the esophageal obturator airway. Reference 6 is a short abstract without information to validate the occurrence of three tracheal intubations and two esophageal tears in 29,000 patients.

The rest of the literature on the esophageal obturator airway is similar to the previously mentioned references. We agree with Dr. Peter Safar: "Except for Schofferman's study, all published reports concerning the EOA thus far have given only anecdotal 'data'". We contend that advocates for the use of the esophageal obturator airway have not proven in a reasonably rigorous scientific way their claims concerning the esophageal obturator airway.

In response to the specific points of Melker and Gordon:

1. In our study the esophageal obturator airway was easily inserted in nine out of ten patients. Two of these easy insertions were into the trachea. Our patients were under surgical anesthesia, relaxed, but not paralyzed, and apneic following controlled ventilation.

Both of us, as advanced instructors in cardiac life support and as trainers of instructors, have had extensive experience in manikins with proper use of the esophageal obturator airway. We think that the esophageal obturator airway was inserted properly in our patients.

2. We were extremely impressed with the ease of ventilation with the esophageal obturator airway in manikins. Based on this experience and as board-certified anesthesiologists, we thought that for the purpose of administering anesthesia, the esophageal obturator airway might be a useful alternative to and might represent a midway point in degree of invasiveness between a mask-oropharyngeal airway system and endotracheal intubation. Our study was begun with a definite positive bias toward introducing the esophageal obturator airway into clinical anesthesia. As anesthesiologists, we must be able to adequately ventilate virtually everybody with one hand on the mask and with one hand on the reservoir bag. If Melker and Gordon want to imply that use of a mask and oropharyngeal airway with an anesthesia circle system is a "worthless adjunct" for mechanical ventilation, then we would construe their communication as an overreaction to our article. We think that in our study the anesthesiologist and the anesthesia circle system were constants, and the observed decreases in the tidal volumes were due only to the change from the mask and oropharyngeal airway to the esophageal obturator airway. We agree that it is easier for anyone to maintain a mask-sealed airway with two hands, and we agree that the use of two hands on a mask would facilitate use of an oxygen-powered trigger device.

3. Reference 5 does not report tidal volumes. We do not deny that it is possible to adequately ventilate some patients with the esophageal obturator airway (70 percent [7/10] in our study). We contend that it is unknown how often patients are not adequately ventilated with the esophageal obturator airway.

4. There is no acceptable documentation of the incidence of tracheal intubation with the esophageal obturator airway before hospitalization. We found an incidence of 20 percent (2/10) for tracheal intubation at the first insertion of the esophageal obturator airway.

5. We agree that the incidence of esophageal trauma should be, and probably is, low and do not wish to imply that this is a major issue.

6. It is possible that if a patient regains consciousness and suddenly and actively vomits with an esophageal obturator airway in place, esophageal damage could occur due to a lack of decompression of esophageal pressure. We agree that the esophageal gastric airway is an advance in this area.

In conclusion, we hope that our report and this exchange will stimulate further research to document what actually occurs with the use of the esophageal obturator airway in these various important areas.

Jonathan Benumof, M.D., Associate Professor 
and C. F. Ward, M.D., Assistant Professor 
Department of Anesthesia 
University of California, San Diego

Chest, 76: 5, November, 1979

Communications to the Editor 613

Downloaded From: http://journal.publications.chestnet.org/pdaccess.ashx?url=/data/journals/chest/21078/ on 06/19/2017
REFERENCES

2 Gordon AS: Clinical experiences with the esophageal obturator airway (EOA) and esophageal gastric tube airway (EGTA). Read before the Third Annual UCLA Postgraduate Institute on Emergency Medicine, Los Angeles, Jan 30-Feb 3, 1978

Reprint requests: Dr. Benufot, Anesthesia Research Laboratory, University of California (SD), La Jolla 92039

Giant Primitive Pleural Hydatid Cyst

To the Editor:

We present the radiologic findings observed in a patient with a giant primitive pleural hydatid cyst which was confirmed at thoracotomy.

CASE REPORT

Our patient was hospitalized because of a continuous pain in the right side of his chest. Physical examination revealed a decrease in the motility of the right hemithorax, dullness to percussion, and abolished transmission of breath sounds.

The roentgenogram showed a large, sharply margi- nated mass occupying the right lower hemithorax. Six days after admission, the patient suffered the abrupt onset of chills, followed by fever and expectoration of vomica that persisted for four days.

After these episodes of vomica, the roentgenographic studies were repeated, showing a huge cavity occupied by multiple rounded and sharply circumscribed shadows that formed an undulated air-fluid level. The tomogram revealed the mobilization of these vesicles into the cavity (Fig 1).

Analytical studies showed marked eosinophilia and a positive Casoni's intradermal test. These radiologic and laboratory findings pointed to a diagnosis of pleural primitive hydatid disease. At thoracotomy a cystic cavity localized in the pleural space was found, containing multiple hydatid daughter vesicles.

Figure 1. Tomogram of right hemithorax after vomica, showing mobilization of daughter hydatid vesicles.

DISCUSSION

Pleural primitive hydatid cyst can be considered to account for 1 percent of all thoracic hydatid disease. Most reported cases are seen as little and homogeneous densities, and the diagnosis of primitive disease was always confirmed at surgery. The mobilization of the daughter vesicles has been considered a sign of secondary pleural hydatid disease, and to our knowledge, such mobilization has not been observed in the primitive form; however, in our patient, primitive pleural localization was confirmed at thoracotomy. We think that the peculiarities observed in this case, such as vomica and mobilization of daughter vesicles into the cavity, are a consequence of the huge size of the hydatid cyst, and we can conclude that these signs cannot reject the primitive origin of the pleural hydatid disease.

Department of Internal Medicine, University Extremadura, Badajoz, Spain

REFERENCES