In response to the comment on too much of anything is bad: An unusual case of a stuck endotracheal tube with deflated cuff

Dear Editor

We thank Kumar et al. for their insightful comments on our letter.\(^{[1,2]}\) The authors give excellent points towards the reason for forming the unusual ring at the proximal end of the cuff.\(^{[2]}\) We agree with the point that while pulling out the tube, the minimal residual air might have squeezed to that end, and when the cuff was deflated, it gave rise to the ring. However, in this regard, it is to be noted that the trachea is not an absolutely rigid structure, and the tracheal ring is deficient posteriorly. Hence, when there is minimal air in the cuff, with traction on the cuff, the air is unlikely to be distributed homogeneously and only in one direction. Nevertheless, when the two factors combine, i.e., pulling the tube leading to accumulation of air towards the proximal end, as suggested by the authors, and too much deflation of the cuff, as mentioned by us, could lead to the situation. Therefore, our point indicating that too much of deflation in a stuck tube can pose an additional problem cannot be summarily rejected.

The 180° rotation we mentioned in our letter is the rotation of the machine end of the tube, which was, of course, not specifically mentioned in our manuscript, and the author rightly indicates that a thermo-elastic polyvinyl chloride tube is unlikely to get a similar amount of rotation at the other end. However, a few points the authors mention regarding patient safety and hastiness need attention. First, the 7 mm ID tube was inserted in the second attempt, because the 7.5 mm ID tube was hard to negotiate in the first attempt, not impossible. Second, to be safer, we only inflated the cuff with an additional 1 ml (over and above the minimal residual volume in the deflated cuff), which is very minimal. The cuff pressure, measured as a part of routine practice in our institute, was found to be not high to cause excessive pressure and edema of the tracheal wall. Third, the 7 mm ID tube was well fit, and there was a leak around the cuff at the leak test, which is already mentioned. Fourth, fiberoptic videoscopic examination was done, which is also apparent from the figure, and it has been mentioned in the manuscript, and we could find no abnormality. The blood tinge only at one point of the nearly hexagonal ring was possibly due to minor injury while the tube was tried to rotate and pull simultaneously. Too much of deflation of the cuff also made this ring sharp and more capable of causing injury. We agree with the author that such a typical ring is not usual in low-pressure high volume cuff, and multiple factors might have worked to have so.

There is no doubt that the authors comment enlightened us and will do so for the readers too. However, our case does indicate that we should be cautious in over-enthusiastic deflation of the cuff in a difficult to extubate case.

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Conflicts of interest
There are no conflicts of interest.
Use of clavipectoral fascial plane block for clavicle fracture: Two case reports

To the Editor,

We report two cases presented with a rib fracture and received ultrasound-guided clavipectoral fascial plane block. This block has the same analgesic effect as the brachial plexus block but can avoid phrenic nerve paralysis and upper limb motor block development. The patients signed a consent form, permitting the use of their relevant medical history and sonographic images for publication in the form of a case report.

The first case was a 37-year-old man presented with clavicle fracture after falling on a snowboard. As he wished to undergo surgical repair, an interscalene brachial nerve block was planned. However, he claimed that his shoulder movement was not good, hence clavipectoral fascial plane and superficial cervical plexus blocks were performed after general anesthesia induction. Ultrasonography revealed fracture of the clavicle. Therefore, about 15 mL of 0.375% levobupivacaine was administered to the fascia on both the medial and lateral sides of the clavicle fracture [Figure 1]. His heart rate and blood pressure were stable intraoperatively, and he did not present any postoperative pain (visual analog scale score [VAS] of 0/10) immediately; no analgesia was used until the next day.

In the second case, a 71-year-old woman with the chronic obstructive pulmonary disease was presented with a clavicle fracture. Respiratory examination showed that the patient's forced expiratory volume in 1 s was <1 L. Thus, clavipectoral fascial plane block, instead of interscalene brachial nerve block, was scheduled to prevent phrenic nerve paralysis. Later, 15 mL of 0.375% levobupivacaine was administered to the fascia on both the medial and lateral sides of the clavicle fracture after the induction of general anesthesia with superficial cervical plexus block. Her heart rate and blood pressure were stable. She presented minimal pain (VAS score of 1–2/10) postoperatively, and no analgesic was used until 13 h postoperatively.

Sensory innervation of the skin that covers the shoulder clavicles and upper thoracic region depends on the supraclavicle nerves of the superficial cervical plexus. It occupies the gap between the pectoralis minor and subclavicle, enclosing both muscles within two layers at the top level. Both fascial layers are attached to the clavicle, forming the pectoral fascia. A circular structure surrounding the entire clavicle and the corresponding nerve endings reach the clavicle by penetrating the pectoral fascia. This type of block comprises injecting 10–50 mL of long-acting local anesthetic into the fascia on both the medial and lateral sides...