

than recommended, it is my normal practice to check the length of the tube against the patient and if this is adequate to use a smaller size tube to minimise nasal trauma. Following intubation the patient was difficult to ventilate with airway pressures of 40 mmHg on squeezing the bag, there was no capnograph trace, no breath sounds and no sounds on auscultating over the stomach. Repeat laryngoscopy confirmed tracheal placement of the tube with the black line being visible just above the vocal cords. Initially the diagnoses considered were anaphylaxis, tension pneumothorax or severe bronchospasm. After overcoming the temptation to administer a small dose of adrenaline (a primitive anaesthetic reflex, I believe) the tracheal tube was removed, the patient ventilated with bag and mask and the situation resolved. He was re-intubated with a size 7 mm Portex Blue Line tube and the case proceeded uneventfully.

When the size 6 mm tube was removed it was noted that the end had folded back on itself (Fig. 1). On closer examination it was apparent that it had bent double at the point where the pilot tube for inflating the balloon pierces the sidewall of the tube.

I believe there are three contributing factors. Firstly, the use of a smaller than recommended size tube meant that there was room for the tube to fold double within the lumen of the trachea. Secondly, the use of Magill's forceps might have also encouraged the bend in

the tube, either by compressing it or making it snag on the anterior tracheal wall or anterior commissure. Lastly, it appears that the Portex Blue Line tubes are susceptible to kinking at the point where the pilot tube pierces the sidewall of the tube. Obviously, care should be used when using soft nasal tubes and Magill's forceps and the appropriate size tube should be used for the patient.

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Propofol and peanut allergy

We would like to draw the attention of readers to the use of propofol in patients with peanut allergy. We were asked to anaesthetise a patient with asthma and a history of nut allergy. Total intravenous anaesthesia using propofol was planned. The product literature of the propofol used in our hospital manufactured by Fresenius Kabi (Propoven, Fresenius Kabi, Runcorn, UK) includes peanut allergy in the list of contra-indications. We checked the product literature of propofol manufactured by Astra Zeneca (Diprivan, Astra Zeneca, Macclesfield, UK) and found that there was no mention of a contra-indication in nut allergy sufferers. In addition, a review of pharmacology textbooks revealed no contra-indication to the use of propofol.

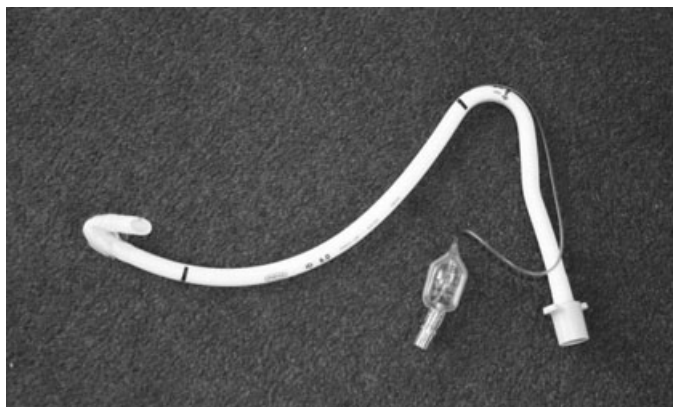


Figure 1 The end of the size 6 mm tube bent back on itself (held with tape for illustrative purposes).

We contacted both Fresenius Kabi and Astra Zeneca and discovered that in 2003 the European Commission published a guideline document as a notice to applicants applying for a licence for marketing medicines. In the annex on excipients and information it states that there is a risk of cross-allergy reactions between peanut oil and soy bean oil and that a warning should be included under '4.3 Contraindications' and '4.4 special warnings and special precautions for use' in the Summary of Product Characteristics (SPC) for all products containing soy bean oil [1, 2].

The licence for Fresenius Propoven was approved in June 2005 under the new regulations. Diprivan, on the other hand, was approved in July 2000 when the regulation did not exist. When the Astra Zeneca licence is renewed, the Diprivan SPC will be updated in line with the 2003 guidelines. Astra Zeneca updated the SPC on the electronic medicines compendium in May 2007 [3].

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