

## Correspondence

### Plasma troponins in the critically ill patient

I found the editorial on troponins by Dr L. I. G. Worthley<sup>1</sup> very helpful. The specificity of troponin rises for myocardial disease seems to me very over-rated. A recent repeated observation that we have made is in patients with anaphylactic shock who often have significant and sustained rises in the troponin levels reported in NSW laboratories. Hopefully we will be able to report this in detail at a later date. However, in the meantime it is of some concern that on the basis of elevated troponin levels there seems to be an increasing tendency to subject these patients to cardiac angiography. Of the four such patients of whom we are aware of, no abnormality has been found on angiography.

It seems to me that the useful thing in such circumstances may be to perform echocardiography when the patient is stable rather than subject them to the more expensive, invasive and hazardous procedure of coronary angiography.

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### Recurrent tracheostomy tube cuff damage following percutaneous tracheostomy

Cuff damage leading to cuff leak is a recognised early complication following percutaneous tracheostomy.<sup>1</sup> We report a case of recurrent cuff leak following damage to previously intact tracheostomy cuffs during percutaneous tracheostomy and the prevention of further damage with the use of tracheal dilating forceps.

An elderly patient with acute respiratory distress syndrome (ARDS) following polytrauma was scheduled for percutaneous tracheostomy to facilitate ventilatory weaning. He underwent an apparently uncomplicated percutaneous tracheostomy using a Portex *ULTRAPerc* tracheostomy set (Portex Ltd., Hythe, Kent, UK). A size 8.0 tracheostomy tube was inserted after confirming the integrity of the cuff. Immediately following insertion and cuff inflation, a persistent air leak was noted, despite the introduction of further air into the cuff. The

tracheostomy tube was removed and perforation of the cuff was confirmed. This occurred on a further two occasions.

Bronchoscopy failed to demonstrate an obvious cause for the recurrent cuff trauma during insertion. A fourth attempt was made, this time using tracheal dilating forceps (Figure 1) to hold the tract open while the tracheostomy tube was inserted over a guide-wire. This was successful and no cuff damage was sustained.



**Figure 1.** Modified Howard Kelly tracheal dilating forceps used to ease passage of the tracheostomy tube.

We propose the most likely cause of the repeated cuff damage to be a fractured tracheal ring, resulting in cuff damage at each insertion.<sup>2</sup> The use of dilating forceps facilitated free passage of the fourth tracheostomy tube. We conclude that tracheal dilating forceps can be a useful aid to successful tracheostomy tube insertion.

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2. Bewsher MS, Adams AM, Clarke CW, McConnachie I, Kelly DR. Evaluation of a new percutaneous dilatational tracheostomy set apparatus. *Anaesthesia* 2001;56:859-864.