CORRESPONDENCE

Advice to the Patient with a Difficult Airway

To the Editor—The review article by Benumof [1] describing in detail the management of the patient with the difficult airway is an excellent and comprehensive analysis of preoperative and intraoperative considerations, but it ignores the postoperative period. In my opinion, our responsibility to patients with this problem does not end with the discharge of the patient from the recovery room. This is not a trivial point. If a patient with an unanticipated difficult airway presents for surgery and after much difficulty the anesthesiologist achieves control of the airway, and if that same patient presents at another hospital at a later date and the same thing happens (or maybe worse), a disservice was done to that patient.

Whenever I have had a patient with a truly difficult unrecognized airway problem, I have made it my practice to talk to the patient postoperatively and give him or her a letter describing in detail what happened, with instructions that if surgery is ever necessary again to be sure to give the letter to the anesthesiologist. Some of my colleagues have even suggested that these patients acquire a medical alert bracelet.

By so informing the patient, a potentially very difficult and sometimes catastrophic situation (unrecognized difficult airway) is converted to a much less difficult situation (recognized difficult airway).

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REFERENCE

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Tracheal Extubation

To the Editor—For routine extubation, Benumof [1] recommends “the patient should breathe 100% oxygen for 2–5 min. Just prior to extubation, the patient should be given a large sustained inflation; while the lung is near total lung capacity, the endotracheal tube cuff should be deflated and the endotracheal tube pulled simultaneously.” The technique described above involves at least three simultaneous tasks being done with two hands. This sequence is easier said than done, particularly by the novice trainee.

We have found the “passive cough technique” is a more consistent way of achieving the same objective and can be easily taught to the trainee. We recommend: 1) The patient breathe oxygen at a high flow (10–12 L/min) for 2–5 min. 2) The pop-off valve is closed. 3) Administer one or two large breaths. 4) When the intrathoracic pressure has risen to 5–10 cmH2O (usually takes less than 10 s), the cuff is deflated and the trachea extubated. This will ensure both a passive cough and a greater certainty that the airway and vocal cords are cleared of secretions.

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A Valuable Alternative for Laryngeal Visualization of the Difficult Airway

To the Editor—A forgotten instrument for easier visualization of the glottic opening during difficult intubations (not mentioned in a recent review) [2] is the Jackson anterior commissure laryngoscope (or Holinger's modification) routinely used by otolaryngologists—head and neck surgeons. Anecdotal references suggest that when the regular laryngoscope blades fail to provide good vision, an otolaryngology scope allows better access. We have used the scope several times for both adults and children. This case describes our most recent use of the scope, which we believe should be used more often.

A 67-yr-old, 136-kg patient with a recurrent nasal basal cancer (large ulcerative lesion involving cartilages and bone) was scheduled for partial rhinectomy, maxillectomy, and cheek rotation flap. Preoperative assessment showed a supple neck and face, a limited airway opening, and a class IV Mallampati score. The patient reported undergoing a

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"difficult intubation" for a thoracotomy at another institution 1 yr previously. Room air oxygen saturation was 90%, which increased to 97% with a mask that partially fit the patient's mouth. An arterial catheter was inserted.

The induction plan was to use oral topical anesthesia with 10% lidocaine spray and to try awake laryngoscopy first, to avoid tracheotomy if possible. No intravenous sedation was given. During attempted laryngoscopy with the Macintosh and Miller blades, no pharyngeal structures except the base of the tongue could be identified. The Jackson laryngoscope (with a xenon light source) was introduced from the left side, displacing the tongue to the right, and clearly showed the vocal cords.

A 6-mm endotracheal tube (ETT) without the connector, with a stylet protruding 1 cm from its end, was introduced inside the scope. Once below the cords, the cuff was inflated, and while the stylet was being held, the scope was gently withdrawn while an assistant held the ETT deep in the pharynx. Dislodgement of the ETT was minimized because it was reasonably anchored by the inflated cuff and the stylet was in place. The procedure lasted less than 2 min without any major discomfort to the patient.

Fiberoptic oral intubation would have been the obvious second choice if direct laryngoscopy had failed. Retrograde wire intubation must be done blindly and might have induced bleeding in the nasopharynx in this patient. Either one of these techniques would have required more time than the Jackson laryngoscope to accomplish the intubation. In addition, this tubular-type laryngoscope is more readily available in any operating room area as compared to an apparently improved version.5

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J-wire Facilitates Translaryngeal Guided Intubation

To the Editor—In a description of retrograde techniques for tracheal intubation,1 Benumof states, "the retrograde guide may be either a guidewire or any type of small-diameter luminal catheter that has a standard hub on the end of it." Several technical problems have prevented general use of this method: 1) the catheter does not pass easily through the vocal cords; 2) it is hard to see a luminal catheter in the oropharynx because of its transparency; and 3) it is difficult to pick up the catheter or a standard guidewire in the oropharynx without damaging the mucosa of the area.

To solve these problems, I have proposed the use of a J-wire, as used for central venous catheterization.2,3 The "J" shape of the wire allows easy entrance between the vocal cords without injury. With the "J" already in the oropharynx, a rotary motion around its axis produces an obvious and easily perceptible displacement within the oral cavity, which facilitates its location. At the same time, separating the tip of the wire from the mucosa makes it easier to pick it up by forceps, thereby decreasing the likelihood of mucosal trauma. I believe that this simple modification can increase the popularity of translaryngeal guided intubation among anesthesiologists.

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The Belscope for Management of the Difficult Airway

To the Editor—In response to Benumof's excellent article,1 I would like to make a few observations regarding the Belscope,2 an angulated laryngoscope blade (fig. 1), particularly with respect to the three points of reservation discussed.

First, it has probably not been widely evaluated because it has either not been readily available (e.g., hidden away on a difficult intubation cart) or has not been purchased at all. I believe it should be more readily available for practice and training purposes, and therefore be

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