Outpatient Anesthesia Should Not Be Limited to ASA Class I Patients

To the Editor—The recent clinical report by Reedy and Zwiren1 points out an extremely rare, but serious, problem. The authors are to be congratulated for recognizing the problem and treating it successfully. However, I would like to take exception to the opinion offered that outpatient anesthesia is "a category reserved for patients only in the best of health." The authors refer to the fact that their patient did not fit into the ASA Class I patient group, which they seem to think are the only patients who can be done as outpatients. A review of the various patient classifications by the American Society of Anesthesiologists reveals that ASA Class II patients are considered to have a mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes. This group includes anyone with a history of allergy, asthma, diabetes, renal disease, heart failure, neoplastic disease, etc. I think patients in the ASA Class II and, occasionally, ASA Class III categories, can be managed as outpatients, but they need to have adequate evaluation and careful postoperative assessment. There are two particular groups of pediatric patients that benefit greatly by outpatient procedures, even though they occasionally may be an ASA Class III category. These include children with neoplastic disease in whom there is a fear of acquiring a hospital infection and severely retarded children who often have a concurrent problem with seizures in whom separation from the parents is extremely traumatic. These patients take a great deal more effort on the part of the medical team, but it is certainly worth the price.

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Reference


(Accepted for publication January 10, 1984)

Another Aid for Nasotracheal Intubation

To the Editor—Although nasotracheal intubation is part of the daily routine, especially in the ICU, it is still associated with some problems.1-5 Due to anatomic variations, nasal passage of the tube sometimes can not be achieved. The slanted tip of the tube may cling to the conchae, may deviate into the mucosal pockets of the retrotonsillar space, or may be stopped by the tuberculum pharyngeum. Possible perforation of the cuff by the uncinate process or other mechanical damage in the narrowed nasopharynx may be a further complication, especially when using low pressure cuffs. In addition, bacteria present in the nasopharynx as well as secretions may cause transmission of infection into the trachea.6

To prevent the above complications, a means for pro-

Fig. 1. Tube and insertion aid ready for nasotracheal intubation.

Fig. 2. Nasotracheal insertion aid, being drawn back through the tube.