

Difficult to intubate, mandatory to oxygenate

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EDITOR:

We read with great interest the paper by Slater and Bhatia [1]. In patients such as the one described in which surgery could represent a potential physical conflict for airway management, airway preoperative evaluation should be rigorous and precise, so as to allow planning of first-line strategy and of a 'plan B' in case of failure. In this case, no such information was available for the reader except for an 'unremarkable' preanaesthetic evaluation and a generic 'some limitations of mouth opening'. According to the Italian Difficult Airway Management Guidelines [2], and representing general commonsense, mouth opening limitation represents, even as an isolated finding, a prediction of potential major difficulty requiring very careful considerations and strategies.

In fact, a reduction in mouth opening, especially in the presence of limited mandibular protrusion, represents a critical step not only for intubation (no space for laryngoscope insertion and/or airway manoeuvres) [3] but also for ventilation with both face-mask [4] or laryngeal mask or other extraglottic devices. So, despite this 'unremarkable' isolated finding, the safest strategy would have been, in our opinion, awake fiberoptic intubation or, in the event of lack of patient cooperation, by fiberoptic intubation in a sedated but spontaneously breathing patient. This is especially so considering of the concomitant presence of facial deformity due to previous surgery and radiotherapy (before which, presumably, ventilation was uneventful).

Insertion of a laryngeal mask in cases of difficult ventilation is an appropriate choice although it may be inadvisable to remove it to perform laryngoscopy, place it again and then finally remove it before proceeding to an asleep fiberoptic intubation. These manoeuvres could have compromised further ventilation or fiberoptic intubation because of bleeding, secretions or minor pharyngo-laryngeal trauma. Italian guidelines prefer direct vision techniques to blind attempts, though recognizing the value of a bougie or, better, of hollow introducers [2]. Particularly, in this case, fiberoptic intubation via a laryngeal mask using the Aintree[®] catheter

(Cook Critical Care, Bloomington, IN, USA), once the laryngeal mask was placed and ventilation was guaranteed [5], could have been the best option. Asleep fiberoptic intubation, we believe, could have led to dangerous desaturation, especially if performed in an apnoeic patient without dedicated devices such as a Berman-like cannula or endoscopy mask. We would finally consider protected extubation (such as over an airway exchange catheter under local anaesthesia) [2] as a strategy for similar cases.

Our message is hopefully clear – might intubation be difficult, guarantee oxygenation first. If either ventilation or intubation is predicted to be difficult, safety first. The fiberoptic awake intubation technique is the definitive choice, particularly in elective situations.

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Cannot ventilate, difficult to intubate

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EDITOR:

We read with interest the letter by Slater and Bhatia [1] and would like to congratulate them on their successful management. We agree that the safest approach for their patient would have been an awake fiberoptic intubation. However, we would like to make a few comments.

From the history and picture, it is not clear whether the patient had a prosthesis fitted into the left orbital cavity. If so it could have deceived the airway assessment at preoperative visit. Difficult mask ventilation is, however, still appreciable as it appears to be impossible to achieve a seal with the face mask. In addition to this, a history of radiotherapy associated with limited mouth opening are ominous signs. Although the patient has had an anaesthetic for grommet insertion, it is possible that a spontaneously ventilating technique with a laryngeal mask airway (LMA) was used. If that was the case, the airway remains unchallenged after the radiotherapy following the initial craniofacial resection. We therefore believe that an awake fiberoptic intubation would have been a safer choice of securing the airway in the first place.

Once the situation of inability to ventilate the patient with a face mask was rescued by the LMA, the difficulty with intubation could have been dealt with one of the two options. Firstly, the trachea could have been blindly intubated via the size 5 LMA. Blind tracheal intubation via the laryngeal mask has been reported [2] and it is recognized as one of the alternative approaches for tracheal intubation in the ASA difficult airway management algorithm [3]. However, the Difficult Airway Society guidelines draw attention to the fact that

the classic LMA is not designed for this purpose and does not recommend blind intubation via the classic LMA. The other option is fiberoptic-assisted intubation through the LMA, which may have a higher chance of success [4]. Secondly, an intubating laryngeal mask airway (ILMA) could have been used. Intubation could then have been blind via the ILMA or under direct vision using the fiberoptic scope. This technique has been used in patients in whom tracheal intubation using traditional methods had failed and also when other known or anticipated intubation difficulties were expected. Using an Aintree catheter with assisted fiberoptic intubation via these supraglottic devices is also reported and well recognized [5–7]. By adopting any of these techniques the oxygenation would have been uninterrupted via a dedicated patent airway while allowing tracheal intubation. It would then have been possible to avoid the nasal route.

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