

Possible additional role for nasal jet oxygen insufflation

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To the Editor:

We read with great interest the recent article by Li et al. [1] in *Journal of Anesthesia* in which the authors describe their use of nasal jet oxygen insufflation to salvage a “cannot intubate, cannot ventilate” situation in a 34-year-old woman, after failed oxygenation via a supraglottic airway device (SGA).

A SGA is described in the 2014 Japanese Society of Anesthesiologists’ airway management guideline as the first-line rescue ventilation strategy [2], but SGA placement in a patient with a restricted mouth opening is difficult. In our emergency room we sometimes encounter patients with trismus, caused, for example, by rheumatoid arthritis or tetanus. Although not specifically mentioned by Li et al. [1], their method may be a promising alternative in a patient with trismus who requires rescue ventilation.

However, their technique may not be suitable in patients with an oropharyngeal injury because the entry of pressurized air into the wound may have serious consequences.

As multiple attempts at endotracheal intubation are known to be associated with an increased risk of upper airway trauma [3], Li et al.’s novel approach should be employed with meticulous caution. In similar scenarios, an alternative approach is awake fiber-optic intubation with nasal high-flow humidified oxygenation, which has recently been described by Patel and Nouraei [4].

References

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