Antegrade vs retrograde insertion introducer for guided intubation in needle laryngotomized patient

To the Editor:

We read with interest the prophylactic use of percutaneous high frequency jet (HFJ) ventilation for difficult intubation in a patient who underwent coronary artery bypass grafting.¹ Because the vocal cords were not visualized by laryngoscopy and fiberoptic intubation apparatus was not available, tracheal intubation was achieved with an introducer passed behind the epiglottis.

Our experience corroborates others²⁻¹⁰ that guided tracheal intubation is a useful technique in difficult intubations, sometimes even more helpful than fiberoptic intubation.⁶⁻⁷ Dr. McLellan and his colleagues did not elaborate the duration of their procedure nor did they describe the difficulty encountered. We believe it would be easier and faster if a soft introducer were inserted retrogradely via the already existing HFJ cannula and a firm introducer were slid over the soft introducer to serve as a stylet. This technique has been described in detail by us.⁹ If this were done, it would not be necessary to paralyze the patient before securing the airway nor would one need a fiberoptic bronchoscope or a jet ventilator.

In reported cases³ using translaryngeal guided intubation (TLI), the cardiovascular variables were stable throughout the cricothyroid puncture and guided intubation.

Prolonged laryngoscopy is very stressful and therefore is of more concern in patients with ischaemic cardiac diseases. Additionally, the needle catheter used for TLI is much smaller and hence much less traumatic than HFJ.

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An alternative use for a nasotracheal tube

The opinions and assertions contained herein are the private views of the authors and are not to be construed as reflecting the views of the Department of the Army or the Department of Defense.

To the Editor:

A general anaesthetic conducted in the prone position is fraught with many hazards, not the least of which is the positioning and management of the endotracheal tube.

We have made extensive use of an orally inserted nasal RAE tube for patients in the prone position and find this a preferable alternative to a straight tracheal tube. The preformed curvature of the nasal RAE tube gives greater resistance to kinking and allows the circuit to extend easily off the head of the operating table. The anaesthetist has ready access to the tracheal tube for suctioning and detection of a disconnect (Figure).