Correspondence

Inhaled nitric oxide as a coadjuvant therapy after massive pulmonary embolism

To the Editor:

Woodward *et al.* reported an interesting case of massive pulmonary embolism occurring in a labouring patient.¹ She was initially treated with oxygen and heparin and an urgent Cesarean section was indicated under general anesthesia. Hemodynamic collapse occurred ten minutes after delivery of an severely asphyxiated baby and a surgical pulmonary embolectomy was performed.

We would like to suggest the use of inhaled nitric oxide (iNO) as a coadjuvant therapy in this critical setting. Some experimental data show that the right heart failure and circulatory shock after a massive air embolism were attenuated when iNO was administered to dogs.² In addition, iNO therapy improved oxygenation and had beneficial hemodynamic effects in four patients with severe pulmonary embolism.³ Besides the selective pulmonary vasodilation caused by iNO, NO inhalation may diminish additional clot formation when emboli reach the lungs.⁴ Although the relevance of these findings remains to be elucidated,⁵ we believe that iNO therapy may attenuate the circulatory collapse and decrease the high mortality rate after massive pulmonary embolism.

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Upper Airway Obstruction

To the Editor:

Once in a great while in the past I have experienced, and I have observed others to experience, problems during the performance of awake fiberoptic-endoscopy aided tracheal intubation similar to those reported by Drs. McGuire and El-Beheiry.¹ Even though glycopyrrolate was used, the fundamental problem has always seemed to be caused by/related to difficulty in handling excessive perilaryngeal fluid (the topicalized local anesthetic and/or secretions) (as in both of the authors' case reports). The perilaryngeal fluid may cause mechanical blockage of the airway, and/or induce laryngospasm, prolonged exhalation, coughing and gagging. As a result of these observations I have made a simple change in my practice which has greatly minimized these problems and difficulties. I instruct the patient, prior to the procedure, that I will anesthetize the upper airway mucosa by spraying a local anesthetic for ten seconds at a time and during and after the spraying of the local anesthetic the patient should gargle whatever fluid accumulates in the back of the throat. I then ask the patient to bring all the fluid to their lips, through which I insert a Yankauer suction catheter and remove all the fluid. The ten second spray-gargle-suction sequence clears the airway every ten seconds and the gargle-suction components are accomplished mainly in breath-hold or exhalation phases (as opposed to an inspiratory phase). In addition, the removal of the local anesthetic may decrease postoperative nausea and vomiting.² Since I have instituted this practice (n = ~ 200 patients),² I have had none of the problems reported by Drs. McGuire and El-Beheiry.

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References

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