overhang the tongue as seen on preoperative airway examination, and restrict the view of laryngeal inlet once the patient is paralyzed under anesthesia.⁵

At present, we observe that patients with a class zero airway may belong to any age group. We have undertaken a study to determine the incidence of Mallampati class zero airway, and its possible correlation with age, sex, body mass index, and other factors.⁵ Until the results of this trial are available, we suggest that all patients with class zero airway should be subject to indirect laryngoscopy to check whether the epiglottis hinders the laryngoscopic view. Furthermore, the ability to ventilate such patients with a facemask must be confirmed before administration of a neuromuscular blocking drug.^{3,5} In conclusion, we disagree with Sakuragi *et al.* that a class zero airway should necessarily predict easy tracheal intubation, and that one should, in fact, be prepared with the "difficult intubation drill" when presented with such a patient.

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Head computed tomography scan following cardiac arrest

To the Editor:

The recent recommendations for patient care following cardiac arrest¹ provide a useful, evidence-based approach to the management of this group of patients. However, some of the recommendations, especially those based on lower grades of evidence, probably need further debate.

The authors suggest that routine computed tomography (CT) of the head is not indicated (grade E evidence). We would argue that CT of the head is indicated in patients who remain unconscious following a cardiac arrest, especially those who are being considered for therapeutic hypothermia.

Kurkciyan and colleagues found that spontaneous subarachnoid hemorrhage (SAH) was the immediate cause of 4% of community cardiac arrests.² The majority of these patients had no prodromal symptoms to suggest an intracerebral event.

Therapeutic hypothermia may not be appropriate in patients who have suffered a SAH. There is no evidence of benefit of therapeutic hypothermia in this group of patients,³ and it is possible that 24 hr of therapeutic hypothermia followed by rewarming would lead to a delay in both the diagnosis of SAH and appropriate surgical intervention. Cooling to 32°C may cause a coagulopathy as a result of impaired enzyme activity and platelet function, which may be detrimental to patients with SAH.⁴

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Reply:

We appreciate the positive comment of Mitchell *et al.* regarding our recommendations for management of patients resuscitated from cardiac arrest. Unfortunately, many recommendations are based on low grade evidence, and we agree further debate and investigation are required. Mitchell *et al.* cite a 4% reported incidence of

subarachnoid hemorrhage (SAH) causing out-of-hospital arrest as justification for routine computed tomography (CT) head scans in post arrest patients who remain unconscious.¹ We agree that therapeutic hypothermia may pose problems in patients suffering from SAH. We note, however, that Kurkciyan *et al.* reported only 4/765 (0.5%) patients arrested following a SAH that was not suspected upon clinical grounds.¹ We do not believe this rate is high enough to justify routine CT scanning in all comatose patients following resuscitation from cardiac arrest. We continue to recommend head CT scans only when clinical findings support ordering the scan.²

We are aware of data that may change the recommendation. Torbey *et al.* have published data combining CT scan results with clinical assessment as a predictor of outcome following resuscitation from cardiac arrest.³ If CT scans can be shown to improve the ability to predict outcome in post arrest patients we could support routine CT scans. At this point we need further evidence to evaluate the utility of the Brain Arrest Neurological Outcome Scale approach or other CT or magnetic resonance imaging based prognostic scores. We anticipate the recommendations will evolve as research is reported, and welcome debate and interest in the topic.

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