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## REFERENCE

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## Emergency airway management (1)

To the Editor:

Bogdonoff and Stone are to be commended on their prudent and practical review of the topic of airway management outside of the operating room.<sup>1</sup> However, the one conclusion that we did not find ourselves in agreement with the authors on concerned the management of the adult patient with epiglottitis. Bogdonoff and Stone seem to support routine intubation of the adult with epiglottitis. This differs from our management which has been one of selective intubation.<sup>2</sup>

It has been our institutional experience that adults with epiglottitis always present with severe sore throat and less commonly (29% of patients) is respiratory distress a presenting feature. It is our impression that adults usually come to hospital earlier in the course of the illness than do children, are more able to communicate their distress than are young children and are less likely to present with the dramatic airway compromise seen in the paediatric patient with epiglottitis. The diagnosis in the adult may be safely made with indirect (mirror) examination or with nasal fiberoptic laryngoscopy and, although this is well tolerated in the adult, direct examination of the paediatric airway in the emergency room is ill-advised. Adult patients without evidence of respiratory distress should be provided with supplemental humidified oxygen, intravenous antibiotics are started and they should be observed in a critical care setting. There must be the capability to intervene quickly to secure the airway should airway compromise occur. It is our opinion, shared by others, that "sudden respiratory arrest" usually occurs in patients presenting already *in extremis* or in those presenting in respiratory distress, who are then admitted to hospital without close observation.<sup>3</sup> Our experience, which is supported by a review of 812 cases from the otolaryngology literature, suggests that intubation, properly carried out in adult patients presenting with respiratory distress, will be required in about 20% of patients.<sup>2</sup> Mortality with an appropriately applied regimen of se-

lective intubation should be less than 1% and is most likely to occur in patients presenting *in extremis* or with respiratory arrest.

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- 2 Crosby E, Reid D. Acute epiglottitis in the adult: is intubation mandatory? *Can J Anaesth* 1991; 38: 914-8.
- 3 Hanna GS. Acute supraglottic laryngitis in adults. *J Laryngol Otol* 1986; 100: 971-5.

## Emergency airway management (2)

To the Editor:

I would like to congratulate the authors Bogdonoff and Stone for their excellent review article on emergency airway management.<sup>1</sup> They correctly note that the fiberoptic bronchoscope is useful for confirming endotracheal placement of the ET tube. While they suggest that "visualization of tracheal rings and the bifurcation at the carina provides absolute proof ...". I would like to relate two cases from my experience that make the above visualization less than absolute proof of correct ET tube placement.

Both cases involved young adult men with acute upper cervical spine fractures. One had associated quadriplegia and required mechanical ventilation for respiratory failure. The other was being anaesthetized for cervical spine infusion. In both cases, the fractures produced a "bulge" in the posterior pharynx which deflected the ET tube anteriorly so that its tip caught on the anterior commissure of the vocal cords. The ET tube was in line with, but external to, the trachea. In one case the intubated patient was transported by air ambulance and mechanical ventilation was continued for a total of 24 hr with the ET tube external to the trachea.

Both cases survived their episodes of mechanical ventilation without mishap. I bring these cases to your attention because an ET tube caught on the anterior com-