

missures can be surprisingly difficult to detect and because the potential for aspiration is high. It can also be difficult to manoeuvre the ET tube past the cords in the presence of a posterior pharyngeal mass. A high index of suspicion is necessary when intubating the trachea in patients with high cervical fractures, or whenever the cuff seems to take more air than usual to provide a seal.

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#### REFERENCE

- 1 Bogdonoff DL, Stone DJ. Emergency management of the airway outside the operating room. *Can J Anaesth* 1992; 39: 1069-89.

#### REPLY

*Thank you for the opportunity to reply to the written comments of Drs. Crosby, Reid, and Ford.*

*We appreciated the comments on management of the adult patient with epiglottitis from Drs. Crosby and Reid. Their experience is clearly greater than our own and their additional insight was welcomed. Perhaps it helps to clarify the rather unpredictable nature of the course of this disease process. In tertiary centres with a referral practice such as our own, one may well be seeing patients later in their course and thus more subject to the airway disasters and higher mortality rates due to mismanagement that are reported in other large series.<sup>1,2</sup> As long as patients not in need of immediate intubation are observed in a critical care setting with the availability of experienced personnel, expectant management is clearly indicated as Drs. Crosby and Reid have explained. We only wish to reiterate that unlike children, not all adults with epiglottitis can be ventilated by mask if and when the need to do so should arise.*

*Dr. Ford has presented two interesting case reports that help to remind practitioners of the continuing need to check and recheck tube placement. We have had similar experiences with tubes trapped in the anterior commissure and being difficult to advance. We have had this problem with blind nasal intubation in elective cervical spine fusion cases and have noted excellent capnographic waveforms and bilateral breath sounds yet some retained ability of the patient to phonate. We believe that use of the fiberoptic bronchoscope is definitive confirmation of intubation in such a case. We look for a patent opening at the end of the endotracheal tube while the bronchoscope is still within the distal lumen of the tube. Any acute angulation of the tube as Dr. Ford has described would be identified by seeing pink mucosa and not a darker tracheal lumen as should be seen while the scope is still within the endotracheal tube. If an unobstructed and patent tracheal lumen is not seen, the bronchoscope should be advanced into the trachea and serve as a stylet for advancement of the trapped tube into the trachea. Quantification of the distance of the endotracheal tube*

*above the carina is possible with the bronchoscope. With the tip of the scope at the carina, one holds the shaft of the bronchoscope at the proximal end of the endotracheal tube. After withdrawal of the scope to the point where the distal tip of the tube just becomes visible, one can measure how far the fingers holding the shaft of the scope have moved. This permits exact measurement although an experienced endoscopist may well be able to judge this visually.*

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#### REFERENCES

- 1 Baxter FJ, Dunn GL. Acute epiglottitis in adults. *Can J Anaesth* 1988; 35: 428-35.
- 2 Mayo-Smith MF, Hirsch PJ, Wodzinski SF, Schiffman FJ. Acute epiglottitis in adults: an eight-year experience in the State of Rhode Island. *N Engl J Med* 1986; 314: 1133-9.

## *Accidental total spinal block (1)*

To the Editor:

There are some aspects of the Clinical Report "Accidental total spinal block: a complication of an epidural test dose" which deserve comment.<sup>1</sup> During the last 30 yr we have seen three cases of high blocks after a single shot subarachnoid injection with 50 mg lidocaine 5% for Caesarean section.<sup>2</sup> It is known that during pregnancy women need  $\frac{1}{3}$  less anaesthetic, in a subarachnoid block, to reach the same level of analgesia than when they were not pregnant.<sup>3</sup> However, in some rare instances, even these smaller doses, especially when combined with lidocaine, may produce a high block, with hypotension and apnoea.

The accident reported cannot be called a "total spinal" as the apnoea resulted from hypotension and not respiratory muscle paralysis: spontaneous respiration restarted as soon as the decreased blood pressure was corrected with a vasopressor and fluids. It seems that uterus dislocation to the left was not done although it may have benefited the baby by increasing venous return. A total spinal usually results when a massive epidural dose of local anaesthetic is inadvertently injected into the subarachnoid space. The drug reaches the cervical segments and blocks the intercostal and phrenic nerves and the apnoea lasts for one or two hours, depending on the agent.

In the same situation, we would have managed the C-section with the spinal, with 100% O<sub>2</sub> given by mask and assisted ventilation, if needed. Midazolam 5 mg would have been used to calm the patient. If the block did not last long enough for the surgery, we would supplement it either with 50-100 mg of fentanyl or with general anaesthesia.