

More on lingual tonsillar hypertrophy

To the Editor:

Davies *et al.* reported their experience with three patients with lingual tonsillar hypertrophy.¹ We recently managed a similar case. A diabetic 57-yr-old female presented for axillo-femoral bypass; she refused regional anesthesia. Following induction of general anesthesia, an obstructing soft tissue mass at the base of the tongue was observed on direct laryngoscopy and tracheal intubation was impossible with both laryngoscopy and with a lighted-stylet. Adequate ventilation was achieved with a size 3 laryngeal mask. Following this event, nasolaryngoscopy revealed lingual tonsillar hypertrophy, with the mass occupying and filling the valleculae and obstructing the view of the epiglottis. Because she derived no symptoms from the lesion, surgical excision was not felt to be indicated.

When re-scheduled for surgery, she again refused regional anesthesia but agreed to awake tracheal intubation. She received glycopyrrolate 0.6 mg *sc*, supplemental oxygen by nasal prongs, incremental sedation and topical anesthesia of the airway. A Bullard laryngoscope fitted with oxygen tubing (8 L·min⁻¹), a dedicated stylet with a size 7 endotracheal tube, and a surgical camera were introduced into the airway. Under video guidance the laryngoscope was passed to the base of the tongue and used to gently elevate the tonsil, allowing the laryngoscope to move beyond and into the laryngeal inlet, visualizing the vocal cords. The trachea was intubated and the procedure proceeded uneventfully.

We agree with Davies that these patients test the limits of our airway management technologies. These lesions are asymptomatic and often unanticipated. They are not readily compressible and may not permit direct viewing of the laryngeal inlet. In one patient, Davies noted the use of an anterior commissure blade, an instrument unfamiliar to most anesthesiologists. However, the more commonly available Bullard laryngoscope is possibly the ideal instrument, both in the anticipated and unanticipated scenario. In the scenario of an airway mass, the Bullard can be fitted with a camera, allowing for visualization of the entire intervention. Its robust construction permits gentle manipulation of airway tissues, allowing it to create the necessary endoscopic airspace. Because it carries the tracheal tube mounted on it, no second working channel is needed for tube placement - an obvious advantage in the patient with a lingual tonsil and a relatively non-compliant airway.

We agree that no single technique or technology can be guaranteed to resolve all airway issues; strate-

gies to manage unanticipated difficult ventilation and intubation must be preformulated and rehearsed. Consideration should also be given to the routine placement of an oxygenation stylet before extubation of the trachea in these patients.

Edward Crosby MD
David Skene MD
Ottawa, Ontario

Reference

- 1 Davies S, Ananthanarayan C, Castro C. Asymptomatic lingual tonsillar hypertrophy and difficult airway management: a report of three cases. *Can J Anesth* 2001; 48: 1020-4.

Unexpected beneficial effect of stellate ganglion block in a schizophrenic patient

To the Editor:

Stellate ganglion block (SGB) is a technique widely used for treating chronic pain in the upper extremities, head, face and neck. Here we report a schizophrenic patient who presented with neck-shoulder pain in whom repeated SGB reduced the severity and frequency of hallucination as well as pain.

The patient was a right-handed 37-yr-old man. At the age of 36 yr, he fell from a horse and developed intractable pain around the neck and left shoulder. After unsuccessful conventional therapies, a course of weekly left SGB was commenced.

Before beginning SGB, the patient often felt that a third person was watching his work and criticizing him. After the first SGB, the third person in his mind became puzzled and less confident. One month later, he felt less noise, and auditory hallucinations changed from mandatory to recommendatory. With discontinuation of SGB, hallucinations worsened. During this period, no anti-psychotic medications were administered. The psychiatrist confirmed the diagnosis of schizophrenia, DSM-IV code 295.3. The Brief Psychiatric Rating Scale (BRPS), which assesses 18 objective and subjective symptoms through interview by a psychiatrist, was evaluated ten days after the last SGB. The BRPS score (min 18 - max 196) was 19, indicating the patient's mental state at this time was close to normal.

Telaranta¹ showed that pathognomonic symptoms of social phobia are alleviated by endoscopic thoracic sympathectomy. Comparable effects would be expect-

ed from SGB which blocks sympathetic efferents originating from the thoracic spinal cord. SGB is known to increase cerebral blood flow on the injected side.² Modified blood flow to the cerebrum may have affected schizophrenia-related symptoms.³ The relaxing effect of SGB may have been additive. We were impressed with this unexpected, beneficial effect of SGB on psychiatric symptoms and suggest that more research in this direction may be warranted.

Manami Takano MD
Yoshito Takano MD
Isao Sato MD
Saitama, Japan

References

- 1 Telaranta T. Treatment of social phobia by endoscopic thoracic sympathectomy. *Eur J Surg* 1998; 580: 27–32.
- 2 Umeyama T. Changes in cerebral blood flow estimated after stellate ganglion block by single photon emission computed tomography. *J Auto Nervous System* 1995; 50: 339–46.
- 3 Ingvar DH, Franzen G. Distribution of cerebral activity in chronic schizophrenia. *Lancet* 1974; 2: 1484–6.

Fast-tracking in ambulatory anesthesia: a new concept? Not!

To the Editor:

A recent editorial in the Canadian Journal of Anesthesia by Song and Chung¹ entitled “Fast-tracking in ambulatory anesthesia” was of interest because my research group has been actively involved in this area of clinical research for many years. Although Duncan and his colleagues² are to be congratulated for achieving successful postanesthesia care unit (PACU) bypass in 83% of their outpatient population undergoing knee arthroscopy procedures, the editorialists erroneously suggested that this was “the first report of a successful (fast-tracking) practice in a community setting.” As a former research fellow at the University of Texas Southwestern Medical Center in Dallas, Dr. Song should have been aware of the numerous papers which our group has published on fast-tracking techniques for ambulatory surgery in both the university and community-based setting. In fact, Dr. Song participated in some of the early studies and co-authored the manuscript³ which described the criteria used by Duncan *et al.*² to determine fast-tracking eligibility in their study. Of interest, in our community hospital-based practice in Los Angeles, 100%

of the outpatients undergoing hernia repair and breast surgery are fast-tracked, with average times to *discharge home* of less than 60 min.^{4,5}

In my opinion, it is unprofessional to knowingly ignore the peer-reviewed literature on a topic when preparing an editorial. While there is clearly a need for further studies on fast-tracking after ambulatory surgery, I would suggest that there are already a large number of published studies demonstrating the safety of fast-tracking programs in this surgical setting.

Paul F. White PhD MD FANZCA
Dallas, Texas

References

- 1 Song D, Chung F. Fast-tracking in ambulatory anesthesia (Editorial). *Can J Anesth* 2001; 48: 622–5.
- 2 Duncan PG, Shandro J, Bachand R, Ainsworth L. A pilot study of recovery room bypass (“fast-track protocol”) in a community hospital. *Can J Anesth* 2001; 48: 630–6.
- 3 White PF, Song D. New criteria for fast-tracking after outpatient anesthesia: a comparison with the modified Aldrete’s scoring system. *Anesth Analg* 1999; 88: 1069–72.
- 4 Tang J, Chen L, White PF, *et al.* Recovery profile, costs, and patient satisfaction with propofol and sevoflurane for fast-track office-based anesthesia. *Anesthesiology* 1999; 91: 253–61.
- 5 Tang J, White PF, Wender RH, *et al.* Fast-track office-based anesthesia: a comparison of propofol versus desflurane with antiemetic prophylaxis in spontaneously breathing patients. *Anesth Analg* 2001; 92: 95–9.

REPLY:

Failure to acknowledge Dr. White’s articles in our editorial was unfortunate but can be explained easily.

In his letter, Dr. White points out that his research group has published numerous articles on fast-tracking techniques for ambulatory surgery in both university and community-based setting. At the time we wrote our editorial, we considered these earlier studies were teaching hospital related researches (including office space anesthesia) and did not represent common practice in the community hospital. Both Texas Southwestern Medical Center at Dallas and Cedar Sinai Medical Center in Los Angeles are affiliated with universities. Therefore we suggested that Dr. Duncan’s study was the first report of successful fast-tracking in ambulatory anesthesia in a community setting, which is more generalizable and applicable to community practitioners. Victoria General Hospital is not affiliated with any university. If our assumptions are incorrect, we apologize for this erroneous statement.