Anaesthetic dilemmas: points for discussion

Anaesthesia for Pierre–Robin syndrome

Sir,

Those of us who express an interest in and experience of anaesthesia for the paediatric patient with a difficult airway will surely wish to congratulate Drs Howell and Walker (Vol 60(9), 1999, p. 688) for their excellent description of a laxative experience anaesthetizing a baby with Pierre–Robin syndrome. We don't call ourselves experts!

I recently had a similar episode with an infant with laryngomalacia and was thankful that the teaching that laryngospasm always breaks before the patient arrests held true that time as well. It is certainly not safe to paralyse a patient when you don't know whether he can be ventilated by face-mask and bag.

Their second dilemma in respect of securing the airway was skilfully managed and they are to be congratulated. I too would wish to intubate the patient and not be comfortable with a laryngeal mask, traction on the hernia sac is a recognized cause of laryngospasm as is emergence in the unintubated patient.

I know of two other approaches.

The first is retrograde intubation as described by Cooper and Murray-Wilson (1987). They used this technique in a baby with Goldenhar syndrome, puncturing the cricothyroid membrane with a Tuohy needle, passing a guidewire up through the vocal cords and using it to guide the endotracheal tube into place.

Second is to use the rigid bronchoscope. I have resorted to this on three occasions in infants with Pierre–Robin syndrome. These cases were of such severity that they required tracheostomy under deep halothane anaesthesia with spontaneous breathing when the larynx could not be visualized with a Wisconsin or Robertshaw laryngoscope.

Conventional laryngoscopy fails because the baby's tongue is too big to be compressed into the (by definition) small retromandibular space. The bronchoscope is much narrower in comparison and therefore can both apply force to a narrower area of tongue and does not need to move as much tongue out of the way to create a straight line between the observer's eye and the patient's larynx.

I wonder if lion taming would be a relaxing hobby?

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Cooper CM, Murray-Wilson A (1987) Retrograde intubation. Management of a 4.8 kg, 5-month infant. *Anaesthesia* **42:** 1197–200

Managing the needle phobic obstetric patient

Sir,

Rees et al (Vol 60(10), 1999, p. 767) reported the interesting case of the needle phobic woman with Grade IV placenta praevia for elective caesarean section. We would like to raise a few points regarding their management.

Considering the amount of trouble taken to get a blood sample before the surgery, it would have been worthwhile if the sampling doctor had inserted an intravenous cannula and taken the sample from that. This would have proved useful to administer the anaesthetic and would have served as a ready intravenous access in event of any sudden haemorrhage.

Second, the authors had mentioned that the patient's peripheral veins were 'barely visible or palpable'. Yet, the second anaesthetist chose to insert a 14G intravenous cannula in the dorsum of the hand after the patient was induced. The chances of failed puncture are considerably greater with a larger bore cannula, especially when the venepuncturist is under pressure to get a quick venous access. The authors should have opted for a smaller cannula (17G or so), which would decreased the likelihood of failure and would have been sufficiently large to rapidly infuse fluids in an emergency. The authors could have also considered identifying two veins in advance rather than only one, which would have covered for any failure in the first attempt.

Finally, we wonder how the anaesthetic assistant ensured that the cricoid pressure was 10N to start with and then 30N towards the end. The wide variability between the amount of pressure which is applied and which the people think they are applying is well known.

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Sir,

I thank Drs Kannan and Potti for their interest in our anaesthetic dilemma. They mention several valid points, two of which I would like to comment on.

First it is evident that had the patient had an intravenous cannula in situ, the general anaesthetic would have been rather more straightforward to administer, but it is not routine practice to maintain prophylactic venous access in patients with placenta praevia who are not in labour and have no symptoms or signs of imminent haemorrhage. Had the phlebotomist (medically-qualified or otherwise) foreseen the problems that ensued from taking a blood sample without first inserting a cannula, perhaps they would have acted otherwise.

With regard to cricoid pressure it is routine for anaesthetic assistants in the hospital in question to practise applying the correct force on weighing scales both on a regular basis and before performing cricoid pressure for real; however, the force applied to this patient was of course not directly measured.

Notwithstanding their comments, however, do I take it that Drs Kannan and Potti would have managed this patient in a broadly similar manner?

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