

Letter to the editor

SHUYA KIYAMA

Department of Anesthesia, Shizuoka Red Cross Hospital, 8-2 Ohtemachi, Shizuoka, 420 Japan

To the editor:

I read with interest the article by Dr. Yurino (J Anesth 8:233–235, 1994), in which he described the use of esophagotracheal combitube (ETC) in a patient with rheumatoid arthritis. I commend him for having successfully managed the case using this airway device, but I would also like to raise an issue regarding the choice of anesthetic in the presence of a known difficult airway. Rheumatic patients have been recognized as being difficult to intubate because of multiple factors, such as cervical spine deformity, temporomandibular joint arthritis, and lesion in the cricoarytenoid joint [1–3]. The patient in Dr. Yurino's report clearly had some of these factors, which had been known to the anesthetist preoperatively. I totally agree with Dr. Yurino that spinal anesthesia would be a reasonable choice for this patient scheduled for her knee operation. However, when general anesthesia is mandatory after failed spinal anesthesia, I must say that intravenous induction and subsequent muscle paralysis could potentially be catastrophic in a patient with anticipated difficult airway. Another point is the force applied during combitube insertion. Excessive neck manipulation should be avoided in rheumatoid arthritics who may have an unstable cervical spine. Both laryngeal mask airway (LMA) and ETC can often be life-saving in a difficult-to-intubate and -ventilate situation, but they are not always effective [4]. Although I admit that these are

very useful devices and every anesthetist should be competent in their use, it should be emphasized that the most important thing when managing patients with potential difficult airway is how to avoid a critical situation in which the anesthetist finds difficulty in ventilation and intubation, rather than how to insert LMA or ETC after casual use of intravenous anesthetics and muscle relaxants. Good clinical judgment in the presence of a known difficult airway should be to intubate the patient awake, or at least, to look at the larynx by either conventional or fiberoptic laryngoscope before the patient is anesthetized [5]. I believe that trainees should not be taught to resort to this novel airway device in the first place. Instead, the take-home lesson for them should be the basics of clinical airway management, "If in doubt, intubate awake."

References

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Address correspondence to: S. Kiyama

Received for publication on June 15, 1994; accepted on July 4, 1994