CORRESPONDENCE

Predicting difficult intubation

SIR,—I read with interest the Editorial by Wilson [1] concerning prediction of difficult intubation. As he stated correctly, “difficult laryngoscopy” is graded as failure to see beyond the epiglottis, that is grade 3 or 4 using the Cormack and Lehane classification [2]. Difficult intubation is hard to define. There are two possible definitions: (1) all intubations which require methods other than conventional oral intubation under laryngoscopic vision in order to be performed successfully may be considered difficult. This category would include those patients in whom a gum elastic bougie was required, as defined by Frerk [3]; or (2) as the threshold for the use of the gum elastic bougie is variable, an argument can be made for excluding all patients whose tracheas may be intubated easily with the aid of a gum elastic bougie as “difficult”. This would include some patients in whom laryngoscopy was difficult [4].

The risk of difficulty or failure to intubate is known to be greatest in obstetric patients [5]. Because many of these patients are known to be anaesthetized by relatively inexperienced personnel (particularly for emergency Caesarean section), the former definition may be more appropriate. As the incidence of difficult intubation using this definition was 4.5% in Frerk’s study, a sufficient number of difficult patients may be studied in order to find a better predictive test than existing ones. The latter definition does not make this possible, as there would be far fewer difficult patients. Wilson suggests that as a consequence, the requirement would thus be for a test to predict “failure to see the epiglottis”. As this is rare, the search for such a test seems pointless.

I agree with Wilson’s statement that no test is likely to be perfect, but this should not discourage workers from seeking a more reliable predictive test or combination of tests than those which are known to be unreliable. Where difficulty is anticipated and general anaesthesia is essential, advanced planning of the anaesthetic is possible and personnel skilled in the use of more sophisticated intubation equipment should be present. Where difficulty is unexpected, a failed intubation drill should be practised and help from a senior anaesthetist enlisted, if not already present.

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Sir,—In his editorial on predicting difficult intubation [1], Wilson summarized much of the recent research aimed at defining the underlying anatomical problems resulting in difficult laryngoscopy, and of that aimed directly at discovering a simple bedside test that will predict difficult intubation. He covered several of the better known clinical tests used currently for predicting difficult intubation. He concluded that as no test is likely to be perfect, it is essential that every anaesthetist must be trained and equipped to deal with unexpected failure to intubate. Researchers in the field would heartily agree; in fact there are already in existence several algorithms for managing the difficult airway, the best known of which is that promulgated by the American Society of Anaesthesiologists [2]. Also, anaesthetists should be guided by a test that a patient could have a trachea that is difficult to intubate. If no testing has been performed and intubation is found to be difficult, there can be no valid basis for claiming that the difficulty was unexpected.

I believe that Wilson has misunderstood the paper by Bellhouse and Doré [3] when he observed that study “failed to predict difficult laryngoscopy reliably”. In fact, more than 60% of the difficult patients were predicted. In each one of the patients that could not be predicted as difficult with the Macintosh, the angulated laryngoscope [4] readily gave a good view of the larynx.

Teviotdale [5] claimed that prediction assessments performed according to a method described in 1988 [6] have proven totally reliable in an environment where difficult intubation is a weekly event. His letter did not make clear if the assessment is entirely reliable per se, or if it is because there has not been an intubation failure at Dr Teviotdale’s hospital since the angulated laryngoscope [4] became available.

Dr Wilson appears to maintain his philosophy, expressed in 1988 [7], that prediction of difficult laryngoscopy is not a reliable tool. Current American and Australian teaching differs in this regard. Because of recognized associations between the difficult airway and physical findings (based both on consultant opinion and on linkage (P < 0.001) for the hypothesis that pre-anaesthetic evaluation predicts a difficult airway), American “Practice guidelines for management of the difficult airway” [2] support an airway physical examination. While “even the most careful pre-assessment will fail to detect some difficult intubations” [8], the recently recorded Australian suggestion is that “an assessment of the airway and degree of difficulty with intubation should be documented on a structured pre-anaesthetic form for each patient” [9].

The point is that anaesthetists use one of the currently available methods for predicting difficult intubation [10], not that there may be little difference between the results of the published methods of predicting difficulty.

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