Editor—We read the review by Conacher\textsuperscript{1} with great interest and recognize many similarities to our own series of 40 patient episodes (39 patients) of central airway stenting between 1993 and 2002. Frequently, however, we have employed a different anaesthetic technique, and we write to record our different experience with this difficult area of practice.

As with the published series, indications for stenting in our unit were numerous, but a majority were patients with malignancy, with significant co-morbidities relating to airway obstruction and the underlying condition. Anaesthetic assessment rarely indicated a need for additional investigations, but rather focused on taking a careful additional history of the patient’s exercise tolerance and limited ability to lie flat.

All patients were anaesthetized in the x-ray suite by a consultant anaesthetist. Initially, only two consultants were involved with such work, although this has now increased to six. After securing the airway, usually by tracheal intubation, flexible bronchoscopy was performed to identify the lesion, and a guidewire was passed via the biopsy port of the bronchoscope. The bronchoscope was then removed and the stent inserted over the wire with fluoroscopic imaging. All the stents were of the self-expanding type, usually Cook Gianturco Z. Repeat bronchoscopy was performed to confirm stent position and opening.

The anaesthetic technique varied; 75% of patients underwent inhalational induction and remained breathing spontaneously throughout surgery. An adapted Boyle’s machine, which could deliver helium, was often used and helium/oxygen delivered throughout induction and the early part of the procedure. In 39 patient episodes, we experienced no significant problems with coughing, recovery from anaesthesia, extubation, or in the early postoperative period. In one patient undergoing bilateral bronchial stenting, one stent failed to expand and could not be removed. This patient died within 48 h of the procedure. We noted prolonged inhalational induction times and significant requirement for i.v. fluids in patients with limited ventilatory reserve and nutrition. The laryngeal mask airway with the aperture bars removed proved useful on three occasions. These patients had high tracheal lesions not amenable to stenting with a tracheal tube in situ.

Ten patients received i.v. induction of anaesthesia and muscle relaxants. Two of these were already ventilated in the intensive care unit and underwent stenting to facilitate weaning (one had airway obstruction due to malignancy and one had tracheobronchial malacia). Retrospectively, we cannot be certain what influenced our choice of anaesthetic technique, but it is our impression that i.v. induction with muscle relaxation and positive pressure ventilation was used in patients with less co-morbidity and less cachexia, who were generally judged ‘fitter’ and in whom a rapid recovery from anaesthesia was predicted. The rigid bronchoscope, although available, has not yet been required.

Currently, as our Boyle’s machine has been decommissioned, we are investigating how a new anaesthetic machine can be adapted to take a helium cylinder.

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Editor—Thank you. I suspect that the modern majority use a similar technique to Strachan and colleagues to deal with the compromised central airway. It has the logic of those who use the obstructed upper airway as a template.\textsuperscript{2} They allude to some of the difficulty with gaseous and self-ventilating induction techniques, certainly existent prior to the arrival of sevoflurane.

The local perspective is one evolved from having to manage these and allied situations with rigid bronchoscopes.\textsuperscript{3} It is particularly useful when things go wrong.\textsuperscript{4} From it, the difficult airway scenario divides into two; central airway obstruction is a very different creature from upper airway obstruction, particularly with regard to the early use of neuromuscular blockade as an aid to securing the airway.

Having recognized that practitioners are more comfortable with familiarity when faced with challenging situations, and having made the above sweeping generalizations, several recent experiences have led me to reintroduce a technique I last used to insert a then-state-of-the-art, Vernon Thompson bronchial blocker. It was satisfying to find that my skills of inserting a rigid bronchoscope in the sedated and self-ventilating patient under local anaesthesia were not completely atrophied, to dispense totally with muscle relaxants, and to bring about resolutions that would have been unlikely had these ASA IV patients been paralysed.

Some of our equipment is also coming to the end of its life; the fall back which may have to be adopted is the manually operated Sanders injector.\textsuperscript{5}

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\begin{enumerate}
\item Conacher ID. Implications of a tracheal bronchus for adult anaesthetic practice. Br J Anaesth 2000; 85: 317–21
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