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## Revival of the Polio Laryngoscope Blade

*To the Editor:*—In 1956, the Polio Macintosh laryngoscope blade\* was specifically designed for poliomyelitis patients, placed in iron lung machines, who required direct laryngoscopy for tracheal intubation. With the advent of simpler mechanical ventilators, this laryngoscope blade has fallen into disuse.

However, there are other conditions which similarly make the proper insertion of a laryngoscope blade difficult, and where the Polio blade can be helpful. Obesity with marked mammary gland hypertrophy, kyphosis with severe barrel chest deformity, short neck and restricted mobility of the neck due to a cervical collar or halo-femoral frame, all fall in this category. We have found the Macintosh Polio laryngoscope blade distinctly advantageous when presented with these anatomic problems.

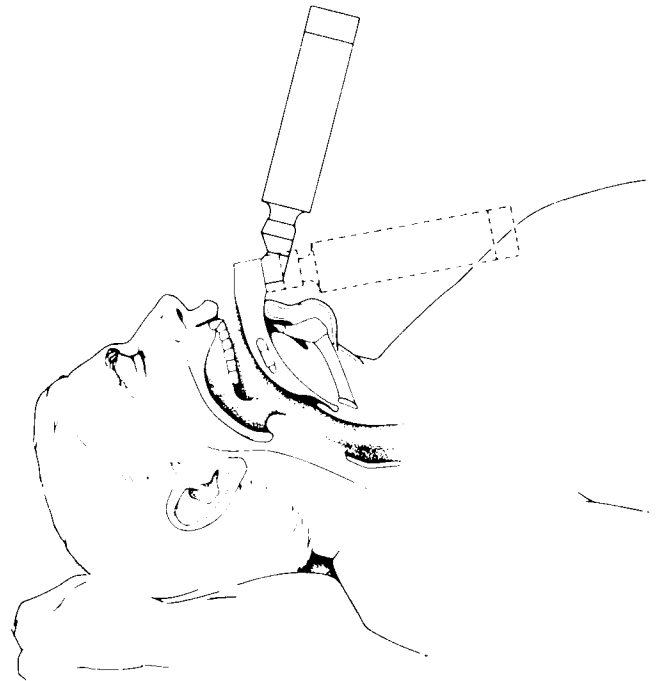
The difference in design of the Polio blade is demonstrated in figure 1. It is connected to the laryngoscope handle at an obtuse angle, whereas standard blades are attached at a right angle. The problem of the handle impinging on the chest of the patient can thus be obviated, and direct laryngoscopy facilitated.

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\* The Macintosh Polio laryngoscope blade is manufactured and available from the Foregger Company.

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Difference in design of the Polio laryngoscope blade.

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## Adult Epiglottitis Revisited

*To the Editor:*—We recently reviewed in ANESTHESIOLOGY our experience with epiglottitis in the adult.<sup>1</sup> We intubated four of five patients and urged early endotracheal intubation as a practical and potentially life-saving maneuver in these patients. Since our report, two more cases have occurred in our institution, one of which is dramatic enough to be worth sharing with the readers of ANESTHESIOLOGY.

A 25-year-old woman developed respiratory distress after having a sore throat and fever for two days. Her respiratory distress became severe enough to cause her companion to phone the emergency paramedic team. In the two minutes it took for the team to arrive, the patient lost consciousness and her companion attempted unsuccessfully to perform a tracheostomy. The paramedics found a cyanotic patient with agonal respiratory

efforts, a pulse of 30, and a systolic blood pressure of 60 mmHg detectable only with palpation. The paramedics were able to place a 6-mm oral endotracheal tube with some difficulty. The patient was given 50 mEq of sodium bicarbonate and transported to the emergency room while being ventilated with 100% oxygen. An initial blood gas analysis in the emergency room showed a pH of 7.23 with a  $P_{CO_2}$  of 32, and a  $Pa_{O_2}$  of 354. The patient was taken to the operating room where direct laryngoscopy revealed a swollen epiglottis but normal and relatively easily visualized vocal folds.

This patient is unusual in that she survived an episode of respiratory obstruction secondary to epiglottitis. It is noteworthy that the epiglottis, while significantly edematous, did not appear large enough to have caused a physical obstruction to ventilation. This suggests that the mechanism of obstruction may be either a reflex obstruction or an inability to handle secretions, and further supports the need for early intervention in these patients even when epiglottic swelling is not severe. We

also found that direct laryngoscopy, while more difficult than in the normal patient, was not so difficult as to make the risk of the procedure weigh heavily against its performance. This case reinforces our prejudice for an artificial airway as soon as possible after diagnosis in this disease.

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### An Aid to Identifying the External Jugular Vein

*To the Editor:*—The external jugular vein (EJV) frequently is used for access to the central circulation or in patients whose peripheral veins are difficult to cannulate.<sup>1</sup> At times it is difficult to maintain the EJV in a distended condition without either an assistant man-

ually occluding it or an extreme head down position (the latter of which may not be well-tolerated). We report an easy to perform maneuver which distends the EJV even in sitting patients without the need for an assistant.



FIG. 1. External jugular vein before (1A, left) and after (1B, right) distension by stethoscope applied to a sitting individual.