Complication Associated with the Use of an Oral Airway

To the Editor—Oral airways commonly are inserted before fiberoptic-assisted intubation in anesthetized patients. These airways help keep the tongue anterior and allow for passage of a fiberoptic bronchoscope. I would like to relate a complication associated with the use of a fenestrated 100-mm oral airway (Gieri, Newark, NJ). A 40-yr-old, 100-kg obese woman presented for excision of a skin lesion of her lower extremity. She refused regional anesthesia and, because of the nature of the lesion, local anesthesia was deemed unacceptable. Physical examination revealed an obese female with a class II airway. Intravenous rapid-sequence induction was performed with 50 mg lidocaine, 180 mg propofol, and 120 mg succinylcholine. Laryngoscopy using a MAC 5 blade was attempted without success. A 100-mm oral airway was inserted, and two-handed mask ventilation was required. A fiberoptic bronchoscope (Olympus LF-2, 3.8-mm OD; Lake Success, NY) was inserted, and the vocal cords and carina were easily visualized. However, the fiberoptic bronchoscope had inadvertently traversed through the distal ring of the fenestrated airway, making passage of the endotracheal tube impossible. The fiberoptic bronchoscope was removed with the oral airway in toto. The patient was subsequently reendoscoped, and the trachea was intubated.

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Possible Link between Social and Biologic Factors in the Epidemiology of Coronary Artery Disease

To the Editor—Investigators interested in the health of populations continue to look for biologic pathways that can connect some of the social determinants of health with the production of disease.1 The results reported by Rosenfeld et al.2 show that plasma fibrinogen concentration increases in human subjects after the infusion of epinephrine, cortisol, or glucagon may add to the understanding of how certain social factors are biologically related to the development of coronary artery disease.

Data from the Northwick and Framingham studies3,4 and other epidemiologic evidence reviewed by Ernst5 indicate that plasma fi-
brinogen concentrations can be used to predict coronary artery disease with predictive power as high as more generally accepted risk factors. Marmot et al. have shown that mortality from coronary artery disease is inversely related to employment grade with a relative risk more than three times greater in the lowest grade of employment compared with the highest grade. Markowitz et al. reported significant differences in plasma fibrinogen concentrations between men in the lowest grades of employment and those in the highest classifications. They also demonstrated a positive correlation between the workers' fibrinogen concentrations and the stress of their respective jobs as determined by a questionnaire composed of items that had been shown to identify stress related to increased risk of coronary artery disease.

Combining the findings of Rosenfeld et al. with the epidemiologic data prompts the speculation that lower social class and employment grade produce stress leading to an increase in circulating epinephrine, which results in increased plasma fibrinogen concentration, which in turn is predictive of coronary artery disease and perhaps causally related.

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Local Anesthetic Test Dose to Predict Effective Epidural Opioid Analgesia: 1

To the Editor.—Weitz and Drasner1 address a clinically important subject, because epidural analgesia is used frequently to provide postoperative analgesia in patients undergoing extensive and potentially painful operations, which may require general anesthesia due to length of surgery or position of patient during surgery. Some anesthesiologists will not give a preoperative epidural dose of local anesthetic adequate to produce motor or sensory block for fear of intraoperative hypotension. Thus, the patient may arrive in the recovery room with no proof of the proper epidural location of the catheter. We agree with the authors’ major conclusion that demonstrable sensory anesthesia is a predictor of good epidural morphine analgesia, because the epidural catheter must be located within the epidural space for epidural analgesia to be effective.

Data by Weitz and Drasner show that, on the operative day, patients with little or no demonstrable sensory block (0–7 points) after testing the epidural catheter with 150 mg lidocaine had mean ± SEM visual analog (VAS) pain scores of 5.5 ± 0.5. These VAS scores were significantly higher than the VAS scores (1.0 ± 0.25) of patients whose catheters were clearly demonstrated to be located in the epidural space (16–24 points), judging by extent of sensory anesthesia after lidocaine injection. Ranges of the VAS scores were not given, but one can surmise maximum VAS score in the former group of patients was about 7 or 8. In our practice, we would consider VAS pain scores higher than 5 to be an indication that epidural analgesia is not effective. In light of absence of expected sensory block after epidural lidocaine injection, we would assume the epidural catheter

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