Sniffing Position Improves Pharyngeal Airway Patency in Anesthetized Patients with Obstructive Sleep Apnea

Shiroh Isono, M.D.,* Atsuko Tanaka, M.D.,* Teruhiko Ishikawa, M.D.,* Yugo Tagaito, M.D.,* Takashi Nishino, M.D.†

Background: Appropriate bag-and-mask ventilation with patent airway is mandatory during induction of general anesthesia. Although the sniffing neck position is a traditionally recommended head and neck position during this critical period, knowledge of the influences of this position on the pharyngeal airway patency is still inadequate.

Methods: Total muscle paralysis was induced with general anesthesia in 12 patients with obstructive sleep apnea, eliminating neuromuscular factors contributing to pharyngeal patency. The cross-sectional area of the pharynx was measured endoscopically at different static airway pressures. Comparison of static pressure-area plot between the neutral and sniffing neck positions allowed assessment of the influence of the neck position change on the mechanical properties of the pharynx.

Results: The static pressure–area curves of the sniffing position were above those of neutral neck position, with increasing maximum cross-sectional area and decreasing the closing pressure at both retropalatal and retroglossal airways. The beneficial effects of the sniffing position were greater in obstructive sleep apnea patients with higher closing pressure and smaller body mass index.

Conclusions: Sniffing position structurally improves maintenance of the passive pharyngeal airway in patients with obstructive sleep apnea and may be beneficial for both mask ventilation and tracheal intubation during anesthesia induction.

THE sniffing neck position, defined as neck flexion with upper cervical extension, is a traditionally recommended head and neck position for induction of general anesthesia unless contraindicated. Compared with the neutral neck position, the sniffing position significantly improves laryngeal view during direct laryngoscopy, particularly in obese persons.1,2 In addition to its advantages in direct laryngoscopy, the head and neck position should preferably accomplish patent airway during induction of general anesthesia, assuring appropriate bag-and-mask ventilation during the critical period. This is particularly important in obese patients with sleep-disordered breathing (SDB) who have narrow pharyngeal airways and rapid development of hypoxemia as a result of reduced functional residual capacity without proper mask ventilation.3,4 Surprisingly, knowledge regarding influences of the sniffing neck position on pharyngeal airway patency in anesthetized and paralyzed persons is still inadequate.5 This prompted us to test a hypothesis that the sniffing position improves pharyngeal airway patency, by studying the influences of this neck position on pharyngeal airway patency in anesthetized and paralyzed patients with SDB, and furthermore, the possible impacts of obesity on mechanical influences.

Materials and Methods

Subjects and Overnight Oximetry

Twelve patients with SDB who were interested in undergoing pharyngeal assessment to determine their indications for uvulopalatopharyngoplasty3,6 participated in this study. All had histories of excessive daytime sleepiness, habitual snoring, and witnessed repetitive apnea. SDB was evaluated by a pulse oximeter (Pulsox-Si; Minolta, Tokyo, Japan). All subjects were instructed to attach an oximetry finger probe before sleep and to remove the probe upon awakening. Digital readings of arterial oxygen saturation and pulse rate were stored every 5 s in the oximeter. The stored data were displayed on a computer screen to check quality of the recordings. The computer calculated oxygen desaturation index, defined as the number of oxygen desaturation exceeding 4% from the baseline, and the percentage of time spent at oxygen saturation less than 90%. Table 1 lists all nocturnal oximetry data and anthropometric characteristics. Although the oximetry evaluation alone do not clarify the nature of SDB, we believe that all patients can be safely diagnosed as having obstructive sleep apnea (OSA) based on the oximetry results and the clinical symptoms.7 The diagnosis of OSA was later confirmed by a standard polysomnography in seven patients (range of apnea/hypopnea index, 19.8–70.1 h−1).

Informed consent was obtained from all subjects after the aim and potential risks of the study were fully explained to each. The investigation was approved by the hospital ethics committee of our institution (Chiba University Hospital, Chiba, Japan).

Preparation of the Subjects

Each subject was initially premedicated with intramuscular injection of 0.5 mg atropine, and placed in the supine position on an operating table, where a modified tight-fitting nasal mask was attached. Care was taken to prevent air leaks from the mask, particularly when the

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airway was pressurized above 20 cm H₂O. General anesthesia was induced and maintained by intravenous infusion of propofol, and intravenous injection of a muscle relaxant (vecuronium 0.2 mg/kg) producing complete paralysis throughout the experiment while the subject was ventilated with positive pressure through an anesthetic machine. Arterial oxygen saturation, electrocardiogram, and blood pressure were continuously monitored. The tip of a slim endoscope (FB10X; Pentax, Tokyo, Japan; 3 mm OD) was inserted through the modified nasal mask and the naris down to the upper airway to visualize the retropalatal followed by the retroglossal airway. A closed-circuit camera (ETV8; Nisco, Saitama, Tokyo, Japan; 3 mm OD) was inserted through the modified nasal mask and the naris down to the upper airway to visualize the retropalatal followed by the retroglossal airway. A closed-circuit camera (ETV8; Nisco, Saitama, Japan) was connected to the endoscope, and the pharyngeal images were recorded on videotape. Reading of airway pressure (Paw), measured by a water manometer, was simultaneously recorded on videotape.

Experimental Procedures

To determine the pressure-area relation of the pharynx, after disconnection from the anesthetic machine, the nasal mask was connected to a pressure-control system capable of accurately manipulating Paw from −20 to 20 cm H₂O in a stepwise fashion. At cessation of mechanical ventilation of the subject under complete muscle paralysis, apnea resulted. Paw was immediately increased up to 20 cm H₂O to dilate the airway, and then gradually reduced, within a 2- to 3-min span, from 20 cm H₂O to the closing pressure of the retropalatal airway in a stepwise fashion (apneic test). The latter represented the pressure at which complete closure of the retropalatal airway occurred, as evident on the video screen. The apneic test was terminated when arterial oxygen saturation decreased below 95%. This procedure of experimentally induced apnea allowed construction of a pressure-area relation of the visualized pharyngeal segment. The subject was manually ventilated for at least 1 min before and after the apneic test. Distance between the tip of the endoscope and the narrowing site was measured by a wire passed through the aspiration channel of the endoscope. Measurements were made for the retropalatal and retroglossal airways both in the neutral neck position (no head elevation, with face straight up) and the sniffing neck position. The head was elevated by approximately 8 cm, with the face straight up, by placing cushions under the head in the sniffing neck position. The mouth was kept closed by a chinstrap.

Data Analysis

To convert the monitor image to an absolute value of the pharyngeal cross-sectional area, magnification of the imaging system was estimated at 1.0-mm-interval distances between the endoscopic tip and the object in range of 5–30 mm. At a defined value of Paw, the image of the pharyngeal lumen was traced, and pixels included in the area were counted (SigmaScan version 2.0; Jandel Scientific Software, San Rafael, CA). The pixel number was converted to pharyngeal cross-sectional area according to the distance-magnification relation. Using known-diameter tubes, the accuracy of the cross-sectional area measurements were tested. For constant distance, the measured areas were systematically deviated from actual areas; the largest-known area tested (0.95 cm²) was underestimated by 11% because of image deformation of the outer image area, and the smallest-known area tested (0.03 cm²) was overestimated by 13% because of reduction of the image resolution.

The measured luminal cross-sectional area was plotted as a function of Paw. The closing pressure was defined as pressure corresponding to the zero area. Because relatively constant cross-sectional areas were revealed at high Paw values, the maximum area (A max) was determined as the mean of the highest three Paw (18, 19, and 20 cm H₂O) values. The pressure-area relation of each pharyngeal segment was fitted by an exponential function, A = A max − B × exp(−K × Paw), where B and K are constants. A nonlinear least square technique was used for the curve fitting, and the quality of the fitting was provided by coefficient R² (SigmaPlot version 8.0; Jandel Scientific Software). A regressive estimate of closing pressure (P′ close), which corresponds to an intercept of the curve on the Paw axis, was calculated from the following equation for each pharyngeal segment: P′ close = ln(B/A max)/K. The shape of the pressure-area relation was denoted as value K. When the pressure-area relation is curvilinear, compliance of the pharynx defined as a slope of the curve varies with changes in Paw; therefore, a single value of compliance calculated for a given Paw does not represent collapsibility of the pharynx for the entire Paw ranges. In contrast, K represents the rate of changes in the slope of the curve; therefore, when K is high, a small reduction in Paw results in a...
significant increase in compliance leading to reduction in cross-sectional area. Consequently, collapsibility of the pharynx increases with increasing K. We suggest that both P'\text{close} and K values represent collapsibility of the pharynx, whereby the former determines the position of the exponential curve, and the latter characterizes the shape of the curve. Reproducibility of the P'\text{close} estimation for both pharyngeal segments was tested in 10 subjects randomly selected from our database. Differences between the first and the second measurements of P'\text{close} ranged from +0.2 cm H2O to −0.9 cm H2O (mean ± SD, −0.2 ± 0.3 cm H2O) at the retropalatal segment and from +0.4 cm H2O to −2.3 cm H2O (mean ± SD, −0.2 ± 0.8 cm H2O) at the retroglossal segment.

### Statistical Analysis

All values are expressed as median (10th–90th percentile). The Wilcoxon signed rank test was used for comparison between the neutral and sniffing neck positions. The Spearman rank order test was performed for correlation analyses between P'\text{close} difference between the positions (ΔP'\text{close}) and anthropometric and oximetry data. P < 0.05 was considered to be significant.

### Results

Static pressure–area relations of the retropalatal and retroglossal airways were successfully obtained from both the neutral and the sniffing neck positions in all patients. As shown in table 1, the study included mild to severe SDB patients with a relatively wide range of age and body habitus.

Figure 1 shows representative pressure–area relations of the pharynx in one patient, demonstrating that the pressure–area curves of both pharyngeal segments in the sniffing position are located above those in the neutral neck position, revealing a larger A\text{max} and a smaller P'\text{close} in the sniffing position. No difference in curve shapes, denoted by K values, was evident between the positions.

Table 2 summarizes the changes in static mechanic variables of retropalatal and retroglossal airways in patients during the neutral and sniffing neck positions. The exponential function reasonably coincided with the measured pressure–area relations as indicated by relatively high R² values. Changes from the neutral to sniffing position significantly increased median A\text{max} from 0.82 to 1.48 cm² at the retropalatal airway and from 2.67 to 3.68 cm² at the retroglossal airway. The K values did not differ significantly between the neck positions. The position change significantly decreased median P'\text{close} from ±2.68 cm H2O to −1.78 cm H2O at the retropalatal segment and from +0.80 cm H2O to −3.72 cm H2O at the retroglossal segment. Figure 2 illustrates individual changes of P'\text{close} at both pharyngeal segments in response to neck position change from neutral to sniffing. Although the highest P'\text{close} within the pharynx was above atmospheric pressure in 10 patients in the neutral

**Table 2. Static Mechanics of the Retropalatal and Retroglossal Airways in Neutral and Sniffing Neck Positions**

<table>
<thead>
<tr>
<th></th>
<th>Neutral</th>
<th>Sniffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retropalatal airway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A\text{max}, cm²</td>
<td>0.82 (0.51 to 1.75)</td>
<td>1.48 (0.88 to 2.15)</td>
</tr>
<tr>
<td>B</td>
<td>1.15 (0.55 to 2.76)</td>
<td>1.08 (0.54 to 1.93)</td>
</tr>
<tr>
<td>K</td>
<td>0.17 (0.13 to 0.26)</td>
<td>0.18 (0.12 to 0.24)</td>
</tr>
<tr>
<td>R²</td>
<td>0.97 (0.92 to 0.98)</td>
<td>0.97 (0.94 to 0.98)</td>
</tr>
<tr>
<td>P'\text{close}, cm H2O</td>
<td>2.68 (−0.62 to +3.97)</td>
<td>−1.78 (−5.22 to +0.36)</td>
</tr>
<tr>
<td>Retroglossal airway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A\text{max}, cm²</td>
<td>2.67 (1.72 to 3.56)</td>
<td>3.68 (1.97 to 5.64)</td>
</tr>
<tr>
<td>B</td>
<td>2.66 (1.27 to 5.85)</td>
<td>2.21 (0.88 to 3.05)</td>
</tr>
<tr>
<td>K</td>
<td>0.18 (0.13 to 0.27)</td>
<td>0.16 (0.10 to 0.21)</td>
</tr>
<tr>
<td>R²</td>
<td>0.95 (0.90 to 0.98)</td>
<td>0.96 (0.87 to 0.98)</td>
</tr>
<tr>
<td>P'\text{close}, cm H2O</td>
<td>−0.80 (−3.08 to +3.28)</td>
<td>−3.72 (−8.43 to −1.73)</td>
</tr>
</tbody>
</table>

Values are presented as median (10th–90th percentile).

* P < 0.01 vs. neutral neck position.

A\text{max} = maximum cross-sectional area; B and K = constants obtained by fitting the pressure/area relation of each pharyngeal airway to an exponential function; P'\text{close} = estimated closing pressure calculated by ln(B/A\text{max})K⁻¹. A = A\text{max} − B * exp(−K * P\text{aw}), where A is cross-sectional area of the pharyngeal airway and P\text{aw} is airway pressure. Quality of the fit is provided by coefficient R².
OSA patients (fig. 3). Higher Pclose was significantly as-

ing less beneficial effects of the sniffing position in obese

highest closing pressure; P

retroglossal segment; RP

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analysis of the pressure–area relation of each pharyngeal segment; RG

Values are presented as correlation coefficients (R) obtained by Spearman

rank order tests.

BMI = body mass index; ODI = oxygen desaturation index; Pclose = observed

highest closing pressure; P′

close = estimated closing pressure by fitting

analysis of the pressure–area relation of each pharyngeal segment; RG = retroglossal segment; RP = retropalatal segment.

Pharyngeal airway size is determined by a precise inter-

action between neural regulation of pharyngeal dilator

muscle activities (neural mechanisms) and structural

properties of the pharyngeal airway (anatomical mecha-

isms).3,9 We recently presented a new conceptual

model for the pharyngeal airway focusing on the ana-

tomical mechanisms (fig. 4). 10,11 Structurally, the pha-

ryngeal airway is surrounded by soft tissue such as the
tongue and soft palate, which is enclosed by bony struc-
tures such as the maxilla, mandible, and cervical verte-
brae. Based on the finding that both obesity and cranio-

facial abnormalities, such as small mandible, contributed
to increased pharyngeal collapsibility, 10 we consider that
the anatomical balance between the amount of soft tissue
within the bony enclosure and the size of the bony

enclosure determines the pharyngeal airway size. Neu-

romuscular mechanisms act as a fulcrum of the balance

model and contraction of pharyngeal dilator muscles
shift the fulcrum to the left, compensating the anatomical
unbalance in the neutral neck position during wake-

fulness (fig. 4, top panel). 12 Total muscle paralysis during
general anesthesia eliminates the neural compensatory
mechanisms and shifts the fulcrum to the right, mani-

festyng the anatomical unbalance and therefore narrow-
ing the pharyngeal airway in the neutral neck position
(fig. 4, middle panel). While eliminating the neural
mechanisms, changes in pharyngeal airway size and col-
lapsibility are attributable to changes in the anatomical
balance.3,10 The bony enclosure size varies with head

and mandible positioning changes even within one sub-
ject. Although the changes in arrangement of bony struc-
tures surrounding the pharyngeal airway were not eval-
uated in this study, an increase in the distance between men-
tum and cervical column should result from upper
cervical extension with bite closure in the sniffing posi-
tion, consequently leading to increase in the bony en-
closure size, which was demonstrated in the magnetic
resonance imaging study by Adnet et al.13 Accordingly,
the sniffing position increases bony enclosure size and
improves anatomical balance, resulting in the increase of
pharyngeal airway size (fig. 4, bottom panel). Although

Discussion

We found that neck position change from the neutral
position to the sniffing position enlarged both retropala-
tal and retroglossal airways and decreased P′

close at both sites by approximately 3-4 cm H2O in completely para-
lyzed and anesthetized patients with OSA. The beneficial
effects of the sniffing position were greater in OSA pa-
tients with higher Pclose and smaller body mass index.
the results of this study coincide with the anatomical balance model, increase in the bony enclosure size may not be the only predominant mechanism for the improvement of pharyngeal airway collapsibility in the sniffing position.

It was found that the sniffing position influences airway collapsibility at both retropalatal and retroglossal segments. It is not surprising to find significant mechanical influences of the sniffing position on the retroglossal airway because tongue musculature originates from and is enclosed by the mandible. In contrast, soft tissue at the level of the retropalatal airway is not enclosed by the mandible, and there is no direct structural connection between the mandible and soft tissue, implying less or no influence of the sniffing position on the retropalatal airway patency. The sniffing position enables the mechanical load relief of the tongue soft tissue from the soft palate, which may be a possible explanation for the retropalatal airway patency improvement in the sniffing position.

Our results indicate less improvement of the retroglossal airway in obese patients with OSA. It is possible that increase in bony enclosure in the sniffing position may be less effective in compensating for the excessive amount of soft tissue in obese patients. The assumption that the sniffing position with the same cushioning produces identical head elevation and cervical displacements may be invalid because of the heavier head and thicker soft tissue of the back in the more obese patients with OSA. Regardless of the mechanism, in obese OSA patients, the use of a higher pillow with a straight-up face position for the maintenance of pharyngeal airway, at least during induction of general anesthesia, is recommended.

Surprisingly, this is the first study to examine the effects of the sniffing position on pharyngeal airway patency in adults during general anesthesia; only the effects of simple neck extension have been reported previously. Shorten et al. reported that sedated children positioned on the sniffing position pillow demonstrated significantly greater nasopharyngeal diameter than those with shoulder elevation, whereas the airway diameter did not significantly differ at the level of the oropharynx and hypopharynx. Although their study population and experimental conditions significantly differ from ours, the limited beneficial effect of the sniffing position partially disagrees with our study in which the sniffing position improved the whole pharyngeal airway patency. Lack of assessment in the neutral neck position as control or structurally stable pharyngeal airway of children without SDB may have elicited the nonsignificant improvement of airway size at levels of the oropharynx and hypopharynx in their study. Our finding that the sniffing position improves airway patency less in patients with less collapsible pharyngeal airways may support the latter speculation. Alternatively, because neural mechanisms were not eliminated in their study, active contraction of the pharyngeal dilator muscles could have successfully maintained patency of the pharyngeal segments without the use of the sniffing position pillow.

Among the five risk factors for difficult mask ventilation identified by Langeron et al., history of snoring, obesity, and advanced age are common clinical features of patients with OSA. In addition, high incidences of fatal intubation difficulty and failure have also been reported in these patients. Accordingly, proper placement of the head and neck to achieve a patent airway for adequate mask ventilation and an unobstructed laryngeal view during direct laryngoscopy is vital, particularly in obese OSA patients. Because the suitability of the sniffing position for the former purpose was investigated by the authors, Adnet et al. examined the superiority of the position for the latter purpose. Both results indicate advantages of the sniffing position over the neutral neck position and equally favorable outcome with simple
Application of triple airway maneuvers with two hands can more effectively establish a patent pharyngeal airway in obese OSA patients for pharyngeal airway patency. Nevertheless, it is recommended that all patients be placed in the sniffing position during induction of anesthesia because the primary goal during this period is to place an endotracheal tube successfully, and a more patent pharyngeal airway can be established by application of triple airway maneuvers with two hands in the sniffing position.

Despite the high incidence of postoperative upper airway obstruction, to our knowledge, optimal head and neck positioning immediately after tracheal extubation has not been examined and documented in anesthesia text books or in the literature. Our results indicate that postoperative use of a pillow is potentially beneficial for maintaining patent pharyngeal airway. Although head elevation with a pillow seems to dose-dependently improve the pharyngeal patency, the possibility of mouth opening or accidental neck flexion, both of which would attenuate the beneficial effects, may increase with pillow height increase. From this context, the clinically optimal height of a pillow would be less than what theory indicates. Accordingly, there is no reason to refrain from postoperative use of a pillow, although a high pillow is not recommended. A pillow specially designed for maintaining the sniffing position is preferable if available. It should be recognized that the sniffing position alone does not completely establish a patent airway and normalize breathing in patients with OSA, as is evident from our observation that four patients demonstrated closing pressure above atmospheric pressure even in the sniffing position. In addition, Kushida et al. found no significant improvement of SDB in severe OSA patients with use of a pillow maintained at the sniffing position, whereas the improvement was evident in mild OSA patients. Application of naso continuous positive airway pressure or nasal positive airway insufflation is necessary to establish patent airway and normalize breathing during sleep immediately after surgery in patients with severe OSA.

We conclude that the sniffing position structurally improves maintenance of the passive pharyngeal airway at both retropalatal and retroglossal segments in patients with obstructive sleep apnea and may be beneficial for both mask ventilation and tracheal intubation during induction of anesthesia.

References


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