CORRESPONDENCE

DIFFICULT LARYNGOSCOPY BECAUSE OF CERVICAL BONY SPICULES

Sir,—Recently, difficulty was encountered during anaesthesia for a 75-year-old man who presented with hoarseness but no history of dyspnoea. Indirect laryngoscopy revealed a small tumour on the left vocal cord but the laryngeal aperture was adequate. Subsequently, the patient was anaesthetized for the purpose of direct laryngoscopy and biopsy.

Premedication comprised atropine 0.6 mg and promethazine 50 mg i.m. 45 min before surgery. On the operating table, it was noted that the patient had difficulty in extension of the neck. Intubation of the trachea under local anaesthesia was not possible and tracheotomy was performed under local analgesia. On placing a pillow under the shoulders, the patient became restless and would not tolerate extension of the neck. The pillow was then removed and tracheotomy performed with great difficulty. After passing a tube through the tracheal stoma, anaesthesia was induced with thiopentone 300 mg and maintained with nitrous oxide in oxygen with intermittent injections of suxamethonium. During attempted laryngoscopy, the surgeon was not able to see the laryngeal inlet and it was not possible to biopsy the lesion of the vocal cord.

Several days later, a lateral x-ray of the neck was obtained and this revealed two large bony spicules extending posteriorly from the 4th 5th cervical spinous processes and the skin of the neck (Fig. 1). Spicule formation in the spine is a rare cause of difficulty in laryngoscopy, but it may be detected in advance if extension of the cervical spine is assessed before anaesthesia and a cervical x-ray obtained in patients with limited movement.

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A NEW BLADE FOR ENDOTRACHEAL INTUBATION

Sir,—Difficult intubations, from time to time, have led many to search for means of intubating without the need for visualizing the larynx. Liban and Liban’s (1977) new blade appears to be a valuable addition to the anaesthetist’s armamentarium. It combines the method of elevation of the epiglottis by pressure in the valleculae described by Reichert (1897) and Rendell-Baker (1963) with features of the “divided airway” (Sykes, 1937; Gillespie, 1963), and Crafoord’s introducer (Crafoord, 1938), and that of Leroy (Leroy, 1827; Mushin and Rendell-Baker, 1953).

When faced with an “impossible” intubation, this new blade may prove to be the answer to many an anaesthetist’s muttered prayer.

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REFERENCES