CORRESPONDENCE

PREDICTING DIFFICULT INTUBATION

Sir,—Oates and colleagues [1] reported a useful study, comparing two published methods of predicting difficult intubation, and have added to the considerable recent literature encouraging preoperative attempts to predict difficult intubation as part of a routine to increase patient safety.

The authors acknowledged how important it is to perform the Mallampati test [2] correctly and, because observer 4 was not doing this during the study, subtracted the results for this observer. This gave a sensitivity to the Mallampati test slightly better than that for the Wilson test [3] and specificity and positive predictive value (PPV) slightly less.

After the authors removed the data of observer 4 from their results, nine difficult laryngoscopies (grades 4 and 5) remained. This makes it hard for the reader to obtain sensitivities of “0.40” and “0.50” in table III for the Wilson and Mallampati methods. Presumably this should have been “4/9”, and “5/9”.

When I reviewed the data presented graphically in figure 3, and subtracted the observer 4 results, I obtained a lower proportion (about 11%) of patients for whom two observers disagreed over scoring when the Mallampati classification was used, than when the Wilson method was used (about 15%).

Previous recommendations have been made that some head extension should be added to the Mallampati technique to improve its accuracy [4, 5], but it is interesting that the single Mallampati predictor gave results comparable to those with the five-point Wilson method, although the Wilson method required five examinations. Although the results were comparable for the Mallampati method with apparently less observer variation (when observer 4 was correctly neglected), the authors preferred the Wilson method. It is significant however, that they declined to recommend it.

The study would have been more valuable if the authors could have analysed their figures further, attempting to discover to what extent adding Mallampati’s examination improved the sensitivity, specificity and PPV of the Wilson classification.

The authors repeated our emphasis [5] that it is important for the anaesthetist to try to predict difficult intubation when presented with a patient at risk of regurgitation.

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REFERENCES


DIPRIVAN INTENSIVE CARE SEDATION IN CHILDREN

Sir,—We have received a number of reports of Diprivan (propofol) use in intensive care sedation of children, a use for which the product is not licensed or tested. Some of these reports have involved the occurrence of adverse neurological events during the recovery phase, ranging from minor twitching to convulsions and have also involved extra-pyramidal events such as choreo-athetosis. The majority of children were aged between 6 months and 3 yr and many were being sedated with Diprivan for acute respiratory tract infections.

A common feature of all these cases is that the doses of Diprivan used (between 6 and 17 mg kg⁻¹ h⁻¹) were far greater than those suggested for adults (1–4 mg kg⁻¹ h⁻¹). Very often, accompanying analgesia was not used to avoid respiratory depression and this may have led to these excessive dose requirements.

We are aware that some doctors may wish to use Diprivan in this patient group, but without further clinical data we cannot recommend or support this practice.

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