THE AIRWAY DECIDES THE ANAESTHETIC APPROACH BEFORE TRACHEAL INTUBATION

Sir,—The review by Cobley and Vaughan [1] dealt with difficult intubation, rather than difficult airways, and therefore seemed incorrectly titled. "Difficult airway" and "difficult intubation" do not always, or necessarily, occur together and they are not synonymous and interchangeable [2]. In the absence of pre-existing compromise of the airway, or its control and maintenance, inability to see the glottis with a laryngoscope does not automatically translate to, or equate with, a "difficult airway" being present. In practice, such an association is uncommon.

The tracheal tube is an airway, but not the airway. Whilst failure to intubate may delay surgery temporarily, failure to maintain the airway, and oxygenation, can cause serious or lethal damage to the patient. Cerebral damage or death are the sequelae, being present. In practice, such an association is uncommon.

Some form of anaesthesia is usually required before tracheal intubation. The decision to use i.v., inhalation or awake local anaesthesia is dictated by assessment and difficulty of the airway, as is the anaesthetic approach to the compromised airway [3]. The choice should err on the safe side and will reflect the anticipated ability (or not) to control or retain the airway with a particular approach. The decision on the airway must be made before induction of anaesthesia. Using i.v. induction agents in sleep does for insertion of a tracheal tube [4] or laryngeal mask [5, 6] when airway control is compromised and uncertain carries considerable risk if the placement of the device proves unsuccessful or difficult.

The value of transtracheal ventilation and of retrograde intubation, especially for the inexperienced, is that they circumvent airway and intubation problems and are possible in the awake patient. Awake intubation is necessitated, not by intubation, but by airway considerations. It seems misused and overused.

Cobley and Vaughan [1] could also have mentioned ketamine and topical anaesthesia in the young [7, 8], nasopharyngeal airways and the possible relevance of the sleep history.

R. WILLIAMSON
University of Natal
Congella, South Africa


Sir,—We thank you for the opportunity to reply.

Most anaesthetists when faced with "the difficult airway" would, in our experience, try to secure that airway with a tracheal tube. The title of our article was therefore chosen with this broad principle in mind. However, we accept that "difficult intubation" would have been more appropriate.

R. S. VAUGHAN
M. COBLEY
University Hospital of Wales
Cardiff

PAIN RELIEF AFTER ANTERIOR CRUCIATE LIGAMENT REPAIR

Sir,—Dr Joshi and colleagues are to be commended for emphasizing the problem of severe pain after knee surgery and for describing their technique of intra-articular morphine infusion [1]. We agree that both PCA and continuous neuraxial infusions are not ideal in this situation.

However, we would have included local anaesthetic neural block in our list of postoperative analgesic alternatives. Both the sciatic and the femoral nerves can be located reliably and blocked with the aid of a nerve stimulator. The duration of high quality analgesia thus obtained frequently exceeds 24 h.

Perhaps, as we enter the age of "pre-emptive analgesia", lower limb peripheral nerve block will begin to receive the attention it deserves.

P. H. CARROLL
J. G. ALLEN
Queen Elizabeth Hospital
Kings Lynn


