consultant support. Surely we have learned, from the Confidential Enquiries into Maternal Deaths,1 that most deaths in obstetrics associated with anaesthesia involve less experienced anaesthetists providing emergency anaesthesia for Caesarean section. When a consultant arrived, however, the management decision was puzzling. In a patient in whom it had been decided that laryngoscopy and intubation were either extremely difficult or even impossible, it was elected to proceed to epidural anaesthesia. What would have been done in the event of an accidental total spinal anaesthetic? In this particular case, the decision to proceed to epidural anaesthesia was taken despite the fact that the patient was only just managing to maintain adequate arterial oxygen saturation breathing oxygen 100%, and was confused and haemodynamically unstable!

This patient should have undergone awake fibreoptic intubation from the start. Anything less borders on negligence. Muddled thinking, as illustrated in this case report, is exactly what leads to disasters.

M. O’Leary
NSW, Australia

Editor—I read with interest the case report by Hinchcliffe and Norris.1 I have serious concerns about the way this patient was managed. The patient, a young, obese (105 kg) nurse, was very unwell on admission and the fetus was in considerable distress. A decision to proceed to Caesarean section was made. Assessment of the patient found her to have a Mallampati score of 3 and a ‘cricothyroid membrane that was difficult to identify’. No reason is given for the difficulty in identification. I assume she had a short fat neck, in keeping with her weight. These factors, in combination with her obesity, indicate there is a substantial risk for her being a difficult intubation, in a population where the risk is only 1 in 300. Nevertheless, the decision to proceed with general anaesthesia was taken, without discussing the case with the consultant obstetric anaesthetist. Surely such a complex case with numerous risk factors demands consultant input at an early stage? Moreover, after induction of anaesthesia, she was given an inadequate dose of succinylcholine (100 mg); a dose of 150 or 200 mg would have been appropriate. I wonder whether incomplete muscle relaxation contributed to the poor view at laryngoscopy? Having anaesthetized and paralysed the patient, why was no attempt made to pass a gum elastic bougie on visualization of the epiglottis? Surely one attempt was warranted.

The other major concern I have is, had you been unable to ventilate the patient after induction, the option for formation of an emergency surgical airway was severely limited because of poor landmarks. I suggest that the decision to proceed with general anaesthesia in someone with serious potential airway problems was inappropriate. The appropriate course of action would have been to perform a regional technique (epidural), or an awake fibreoptic intubation at the outset. Although systemic infection is a relative contraindication to regional techniques, Chestnut found only one case of epidural infection in 500 000 obstetric epidurals, with an assumed incidence of 1% bacteraemia. If we assume this episode of epidural infection occurred in one of those patients who was bacteraemic, this indicates a risk of 1 in 5000 for developing epidural infection in such patients compared with a risk of less than 1 in 300 for a serious airway problem on induction of general anaesthesia in the obstetric population. Of the 531 patients in the study by Goodman and colleagues,2 none developed epidural or spinal infection despite having a regional technique in the presence of chorioamnionitis. Although there is a theoretical risk for seeding infection in the epidural/spinal spaces in those who are bacteraemic, hard evidence appears to be lacking in patients

Management of failed intubation in a septic parturient

Editor—I was dismayed to read the case report from Hinchcliffe and Norris1 ‘Management of failed intubation in a septic parturient’, which actually presents an example of how to not manage a difficult obstetric case! In the first instance, trainees were left to, or decided to, take on a high-risk case without
Correspondence

M. F. Dunsire
London, UK

Editor—Thank you for the opportunity to reply. Dr O’Leary appears to misunderstand the role of case reports of this type, which is partly for interest, and partly to illustrate some wider lesson. The lesson in our case is that regional anaesthesia may remain the obstetric anaesthetist’s best option, even when systemic infection is present (albeit after antibiotic treatment). Dr Dunsire makes a similar point. Our description of events does not pretend to be an essay on how to manage such cases.

The suggestion that the case was mismanaged because of lack of experience on the part of the senior trainees involved is misplaced. The specialist registrars both possessed the FRCA, in addition to several years experience of obstetric anaesthesia. Only in the UK and Eire would such doctors still be part of a training scheme, and this is reflected in the nature of their clinical responsibilities. The decision to request additional assistance from a colleague with particular experience or skills reflects sound clinical practice not lack of competence.

In contrast to Dr O’Leary’s remarks, the management of this case enshrines many of the principles contained in maternal mortality and CEPOD reports; a formal assessment of the airway was made, assistance was requested, preparations for difficult intubation were made, a failed intubation drill was adopted promptly without repeated attempts, and intensive care was involved early.

Both correspondents suggest that awake fibreoptic intubation should have been performed from the outset. Indeed, Dr O’Leary says not to do so verges on negligence. We disagree. We acknowledged in our report that awake intubation might have been the best option, but there is no consensus on when this is indicated on the basis of predictive factors, and the problems with this approach have been summarized by Yentis. Even when awake intubation appears to be indicated, a cooperative patient is still required. Is a woman with a fever in advanced labour with fetal distress likely to be cooperative? The ASA difficult airway guidelines suggest regional anaesthesia (as in our case) or fibreoptic intubation under anaesthesia as options in this context.

Even if the indications for awake intubation were clear, which they are not, it is futile to argue, as a current standard of practice, that all potentially difficult cases undergo awake intubation, when the reality (at least in the UK) is that most anaesthetists lack the necessary skills, training and equipment, especially for a case like this. Difficult cases require knowledgeable, skilled doctors to exercise their clinical judgement, not the reflex application of a single ‘solution’.

A. M. Norris
D. Hinchliffe
Nottingham, UK