

Endobronchial intubation technique and airway morbidity

Editor—We read the interesting article by Seo and colleagues about the study comparing two techniques of double-lumen endobronchial intubation. We have a few queries.

First, the authors have not mentioned if any lubrication or softening technique was used to prepare the double-lumen tube (DLT) before placement to prevent airway morbidity.

Secondly, the authors have not mentioned whether there was any correlation between Cormack and Lehane’s grading and resistance to pass the DLT.

Thirdly, the authors discussed a better antero-posterior alignment at the level of vocal cords in the group 180 leading to decreased resistance to placement of DLT and subsequent less vocal cord morbidity, but what could be the possible reason for more sore throat in the group 90 in comparison with the group 180?

Declaration of interest

None declared.

P. Maheshwari*

P. Maheshwari

Oklahoma City, USA

*E-mail: praveen-maheshwari@ouhsc.edu


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180° rotation of double-lumen endobronchial tube during intubation

Reply from the authors

Editor—We would like to thank Drs Maheshwari for their comments and interest in our article. First, in both groups, we did not use any known modalities to reduce airway complications during tracheal intubation. Therefore, we think that there were no problems during the conduct of our study. Secondly, in all 164 recruited patients, we analysed the correlation between Cormack and Lehane’s laryngoscopic grade and the resistance during advance of double-lumen endobronchial tubes (DLTs) through the glottis by using Fisher’s exact test, but no correlation was found ($P=0.878$). The resistance during advance of DLTs seems to be more associated with the difference in the size between the DLT and glottis rather than the laryngoscopic grade. However, a further and larger-scale study may be needed. Thirdly, sore throat can occur owing to various factors related with tracheal intubation. However, it is clear that the intensity of physical trauma during the DLT intubation is the major causative factor. The 180° rotating technique reduces resistance during advance of DLTs through the glottis as shown especially in nine patients in whom the 90° rotating technique had not been successful.

Declaration of interest

None declared.

J.-H. Bahk*

J.-H. Seo

Seoul, Republic of Korea

*E-mail: bahkjh@snu.ac.kr


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In pursuit of interscalene safety

Editor—I read with interest the case report by Mostafa and Mejad documenting quadriplegia after shoulder surgery, and laud the authors for unveiling this complication.

Benumof published a four case series highlighting quadriplegia as a complication of interscalene block (ISB) performed under general anaesthesia. On reflection, he opined that performing an ISB under general anaesthesia constituted a relative contraindication. Furthermore, he recommended that block needles should not exceed 3.75 cm in length, that they be directed caudally, and notably, that landmarks are poor in obese patients. At variance, Bogdanov and Loveland presented a retrospective analysis of 548 cases of ISB/general anaesthesia that failed to reveal a single case with permanent or long-lasting neurological complications.

Sardesai and colleagues performed a magnetic resonance imaging study in 10 volunteers examining needle angulations that facilitate passage into the neuraxis. They found that at the C6 level, a caudad angulation of >30° ensured passage of the needle below the intervertebral foramen. In a similar fashion, Russom and colleagues using a cadaver model concluded that marked caudal angulation (>50° to transverse plane) minimized the chance of needle entry into the spinal canal.

Quadriparesis after ISB may result from delayed epidural or intradural extension of local anaesthetic (LA) after injection into the dural cuff. Orebaugh and colleagues injected dye into the brachial plexus roots of cadavers under ultrasonic guidance. They were testing the hypothesis that LA injected into the proximal portion of a plexus root can spread to the cord. An earlier study by Selander and Sjostrand documented intracordal spread in association with high injectate pressures (300–750 mm Hg). In contrast, Orebaugh witnessed distal

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