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JOACP_445_12R6_LTE

Use of a laryngoscope, held sideways, as an aid in performing an intraoral glossopharyngeal nerve block

Sir,

Anesthetizing the glossopharyngeal nerve (GPN) is an important component in achieving successful airway anesthesia and is necessary for both awake oral and nasal tracheal intubations. The clinician should recall that the GPN is the IX cranial nerve and that it innervates the posterior third of the tongue, epiglottis, as well as the soft palate.[1]

Anatomically, the intraoral GPN nerve block can be accomplished by injection of local anesthesia at the base of either the anterior or posterior tonsillarpillars.[2] This can be facilitated by using a laryngoscope, held sideways, for medial retraction of the tongue [Figure 1]. It is the authors' observation that this provides excellent visualization of these structures; with less potential for gagging then traditional caudal tongue retraction. When held in this manner, the laryngoscope subsequently also functions as a bite block. Typically, a 22 to 25 gauge Quincke point spinal needle is then used to inject 4 to 5 ml of 2% lidocaine. For patients with small mouths, limited inter-incisor distance, or with mild to moderate trismus, pediatric laryngoscopes may be used. Furthermore, Miller laryngoscope blades, which are usually narrower than Macintosh, may also be advantageous.

Figure 1: By holding a laryngoscope sideways, the tongue can be retracted medially. This facilitates the visualization of either the poster or anterior tonsillar pillars during the administration of an intraoral glossopharyngeal nerve block

In addition, the use of a video laryngoscope such as the Glidescope® may also facilitate proper localization. This device may also be educationally valuable.

For those patients with severe trismus, the extraoral GPN block may be necessary.[1] Careful aspiration is always essential with either the intraoral or extraoral approaches; as the GPN is located near the carotid artery.

In addition, "redundant" local analgesic techniques, with topicalization of the tongue as well as nebulized lidocaine, are beneficial prior to performing this block. Use of both the transtracheal and superior laryngeal nerve blocks are also indispensable for awake tracheal intubation. Whereas topical anesthesia, of the sphenopalatine ganglion and nasal mucosa, are additionally needed for awake nasa l intubation. Judicious use of intravenous sedatives may also be beneficial.[1] Pretreatment with sodium citrate and metoclopramide is necessary if a "full stomach" or gastroesophageal reflux is known or suspected.[3]

The patient's ability to tolerate either a traditional Berman or Guedel oral airway may be used as an indication of adequate overall intraoral anesthesia. Fiberoptic-compatible oral airways should also be available.[4]

It should be noted that awake intubation can be accomplished with a traditional laryngoscope, video laryngoscope, or fiberoptic bronchoscope. "Blind" intubation techniques can also be employed. These may be facilitated with the use of an

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"intubation whistle" or by the auscultation of breath sounds emanating from the proximal end of the tracheal tube.[5]

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JOACP_286_12R6_LTE

Successful placement of double lumen endotracheal tube using fluoroscopy

Sir,

Fluoroscopy is increasingly available in operating rooms. There are reports of fluoroscopy use for intubating the trachea in patients with difficult airway,[1] positioning an endobronchial blocker,[2] anterograde intubation[3] and endobronchial placement of a single-lumen endotracheal tube in a children.[4] We used fluoroscopy to successfully position a double-lumen tube (DLT) in the left main stem bronchus after failed attempts with standard technique using direct laryngoscopy and flexible bronchoscopy.

A 65-year-old man with carcinoma lung presented with a two-week history of hemoptysis and was scheduled for embolization of the culprit vessel, by interventional radiology, under general anesthesia. A preoperative computerized tomography scan showed that the endobronchial stent traversing the distal bronchus-intermedius and right lower lobe bronchus had debris and was plugged causing partial collapse of the right middle and lower lobes. Extensive radiation fibrosis in the right hilum and medial upper lung zone was also noted with right-sided tracheal deviation.

Standard monitoring was initiated. A radial arterial catheter was placed and general anesthesia was induced. A left-sided 37 Fr Mallinckrodt double lumen endotracheal tube using standard technique with direct laryngoscopy was placed.[5] Fiberoptic bronchoscopy showed right mainstem intubation and so repositioning the tube was attempted using flexible bronchoscopy. Visualization was poor due to bloody secretions, although frank bleeding was not seen. On visualization of the carina, the fiberoptic scope was passed into the left mainstem bronchus, which appeared to be stenotic. We were unable to slide the tip of the DLT into the left main bronchus despite using various rotational maneuvers.

Fluoroscopy was used to visualize the location of the DLT, which was in the right main stem bronchus [Figure 1]. Under fluoroscopic guidance, we were able to perform the rotational maneuvres and slide the DLT gently into the left mainstem bronchus. These maneuvers would have been difficult or impossible without real-time visual guidance.

Fluoroscopy may prove to be an invaluable tool, when insertion is difficult through a flexible bronchoscope because of hemoptysis, bronchial deviation and scarring. The use of fluoroscopy was simple and efficient in this situation. Cohen *et al.*[4] found that after a limited amount of instruction, trainees were able to master

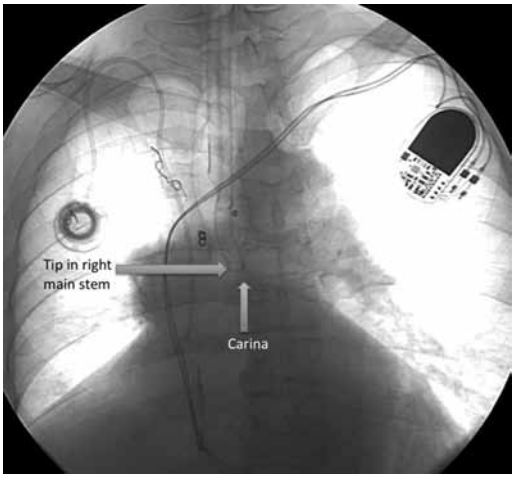

Figure 1: Fluoroscopic frontal image of the chest shows marked right hilar fibrosis, right sided tracheal deviation and the double lumen tube in the right main stem bronchus (arrow)