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Difficult tracheal intubation; improvements in trans-laryngeal guide wire techniques

C. E. BLOGG, M.B., F.F.A.R.C.S. & M. E. WARD, M.B., F.F.A.R.C.S.

Nuffield Department of Anaesthetics, The Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE.

Many solutions have been proposed for achieving tracheal intubation in patients with anatomical abnormalities which preclude the conventional use of a laryngoscope. The use of a guide passed in a retrograde direction into the mouth via the larynx (Waters, 1963) or trachea (Ramsay and Salyer, 1981) has proved useful by allowing the tracheal tube to be guided over the guide from the mouth or nose into the larynx. Greater control is achieved by the use of a relatively rigid wire (Ramsay and Salyer, 1981; Roberts, 1981; McLean, 1982) but passage of the tube into the trachea is impeded by the guide protruding

through the skin of the neck. If the guide is removed the risk of displacing the tracheal tube as it is advanced is increased.

The risk of losing control of the direction of advancement of the tracheal tube is reduced by passing a second spring-ended flexible guide wire down the tube, past the wire introduced through the neck, and into the trachea before withdrawing the wire from the neck. A further modification of the technique involves using a long suction catheter passed down the advancing tracheal tube through which breath sounds can be heard, oxygen can be supplied and suction can be applied. These techniques were used in 2 cases of hemifacial microsomia.

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The following papers were also read at the meeting:

Neuromuscular blockade in the burned child: F. WHAN, F.F.A.R.C.S.

Anaesthesia for burned children—10 years on: E. VIVORI, F.F.A.R.C.S.

Induced hypotension for plastic surgery—a review: P. TATHAM, F.F.A.R.C.S.