the upper arm resting over their head. The operator stands behind, with the ultrasound screen in front of the patient (Fig. 3). In our experience, this makes it easier to control the ultrasound probe and facilitates block performance. Sagittal images of the ribs are obtained by placing a linear probe in line with the midaxillary line. Second, a 100-mm needle is introduced in-plane from an inferior to superior direction. The length of the needle enables administration of local anaesthetic across up to three intercostal spaces above the level of insertion. From the two approaches described by Blanco et al, we usually choose the one deep to the serratus anterior muscle, as it seems to provide a good anterior distribution [1] of the block. In addition, many of our patients are thin, so the serratus anterior muscle is not very prominent and the deep plane is more easily identified. The procedure is repeated on the contralateral hemithorax. It usually takes approximately ten minutes to block the two hemithoraces. Patients report good analgesia and are usually discharged the following day without the need for rescue analgesia.

O. Diaz-Cambronero
J. Ortega-Monzó
Hospital Universitario y Politécnico La Fe, Valencia, Spain

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Oxygenation during difficult airway management

Together with subsequent correspondence [1, 2], we read with interest the article by Patel and Nouraei [3] about using transnasal humidified rapid insufflation ventilatory exchange to increase apnoea time in patients with difficult airways, and have a few comments on these.

The technique described by Ungureanu and Mendonca [1] could prolong the apnoea time, but their solution will preclude being able to use a tracheal tube stylet during difficult intubation. Neither their nor Khan et al.’s technique [2]
would be suitable when providing positive pressure ventilation via a facemask during prolonged laryngoscopy and intubation.

Instead, we propose that a tracheal tube connector attached to an appropriately sized nasal airway (Fig. 4 left), with this assembly inserted into the nostril and connected to the ventilator circuit (Fig. 4 right), may offer an alternative, as it can be used for continuous oxygen insufflation via the ventilator circuit without interfering with the laryngeal view, in the event of prolonged laryngoscopy and intubation. In addition, this assembly can be used for positive pressure ventilation without the need for removing the modified nasal airway, avoiding hypercapnia.

P. Maheshwari
University of Oklahoma Health Science Center, Oklahoma City, USA
Email: praveen-maheshwari@ouhsc.edu

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Ventilation success masks our prediction failure

In an audit of 14 480 cases of laryngeal mask anaesthesia [1], Saito and colleagues found ventilation difficult in only 0.5%. This finding is important and undeniably impressive, but a number of confounding issues need to be taken into account.

Firstly, laryngeal mask cases represented a subset of a cohort numbering 37 800, but the composition of excluded cases was not specified. The airways of patients with a history of difficult laryngeal mask anaesthesia may have been managed using other techniques. Other patients with predicted difficult airways may have received regional anaesthesia. Such exclusions may have affected both success rates and identifiable risk factors.

Secondly, it is uncertain whether the results presented, involving a slim south-east Asian population, are generalisable to other patient populations.

Thirdly, four risk factors were identified for difficult laryngeal mask use, of which short thyromental distance was found to be the most significant. However, the predictive value of short thyromental distance was low, being present in only 19% of difficult cases, with over 97% of patients with a short distance not difficult to ventilate. As with difficult intubation and mask ventilation [2–4], the complication is rare and the risk factors are non-specific, so the false positives far outnumber the true positives. In other words, because difficulty in laryngeal mask ventilation is rare, anaesthetists will usually fail to predict it.

Finally, the authors did establish another important predictor, however, namely their detailed airway record. A history of actual airway difficulty has high clinical value in subsequent airway planning, as does a clear note of its absence. It is disappointing, then, that a recent American audit found that airway records are inadequate in most anaesthetic charts [5]. Perhaps we should focus more on checking and making good airway records rather than the holy grail of correct prediction.

J. Nielsen
Concord Hospital, Sydney, Australia
Email: jamesnielsen@gmail.com

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