DANIEL W. LANG, M.D.
Assistant Anesthesiologist
Massachusetts Eye and Ear Infirmary and
Instructor in Anaesthesia
Harvard Medical School
Boston, Massachusetts 02114

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Acromegalic Patient—Indication for Fiberoptic Bronchoscopy But Not Tracheostomy

To the Editor:—Southwick and Katz[1] recommend that elective tracheostomy be performed either preoperatively or prior to removal of the endotracheal tube when a difficult intubation is encountered in acromegalic patients with glottic or soft-tissue abnormalities. It is well known that tracheostomy is not an innocuous procedure, and carries certain risk and complications. I submit that the complications of a difficult intubation could have been avoided by the use of a fiberoptic bronchoscope. When faced with a difficult intubation, familiarity of the anesthesiologist with the use of the fiberoptic bronchoscope would assure an atraumatic endotracheal intubation and avoid the need for tracheostomy, either pre- or postoperatively.

BAHMAN VENUS, M.D.
Assistant Professor of Anesthesiology and
Medical Director of Respiratory Therapy
University of Illinois
840 South Wood Street
Chicago, Illinois 60612

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Headache Immediately Following Attempted Epidural Analgesia in Obstetrics

To the Editor:—A recent paper in ANESTHESIOLOGY brought attention to transient headaches occuring shortly after epidural steroid injections.[1] The authors stated that they were unaware of any reports of such headaches occurring after attempted epidural anesthesia for labor and delivery. We have observed two such episodes in obstetric patients.

Patient 1. A 33-year-old woman, gravida 4, para 3, requested epidural analgesia for labor and delivery. The patient was placed in the right decubitus position and an 18-gauge Tuohy epidural needle was placed by loss-of-resistance (LOR) technique with saline solution and 2 ml air in the L3–4 interspace. Dural puncture inadvertently occurred and was documented by aspiration of approximately 1 ml cerebrospinal fluid. Local anesthetic was not injected. The patient complained immediately of mild frontal cephalgia. The epidural needle was removed and replaced successfully with another at the L2–3 interspace using LOR technique with saline solution. The patient continued to complain of headache, which was exacerbated by elevation of the head. Sodium chloride, 0.9 per cent, (40 ml), was injected through the epidural catheter, with immediate relief of the cephalgia. Six hours later an additional 40 ml of saline solution were injected prophylactically, and the epidural catheter was removed. The patient underwent an uneventful cesarean section and was discharged several days later without further anesthetic complication.

Patient 2. A 31-year-old woman, gravida 2, para 1, requested epidural analgesia for labor and delivery. An 18-gauge Tuohy epidural needle was placed in the L3–4 interspace with LOR technique using 5 ml air. A catheter could not be advanced into the epidural space, so the needle was removed and repositioned again in the L3–4 interspace with LOR using 4 ml air. The patient described a paresthesia in the right leg and severe fronto-occipital headache upon "epidural" entrance. Aspiration yielded no cerebrospinal fluid. The needle was removed. The patient delivered a healthy infant during mask nitrous oxide–oxygen analgesia. The headache persisted. It was exacerbated when the patient was up-