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Airway Management in Patients with Acromegaly

To the Editor:—Anatomical changes involving the airway in patients with acromegaly and the potential problems these airway abnormalities may pose for the anesthesiologist have been reviewed by Southwick and Katz,[1] Ovassapian *et al.*,[2] and us.[3] Southwick and Katz suggested that patients with glottic abnormalities or both glottic and soft-tissue abnormalities ". . . should probably undergo tracheostomy either preoperatively or prior to removal of the endotracheal tube."[1] They did not mention use of the fiberoptic bronchoscope to facilitate endotracheal intubation in acromegalic patients in whom conventional laryngoscopy would be difficult. We agree with Venus[4] and Ovassapian *et al*[2] that, although tracheostomy may be required for postoperative as well as intraoperative airway management in some advanced acromegalic patients, tracheostomy has its own risks and complications.[5,6] Fiberoptic laryngoscopy can facilitate what otherwise would be a difficult endotrocheal intubation and may prevent unnecessary tracheostomies in patients with acromegaly.

We recently reviewed our experience with 94 acromegalic patients who underwent transsphenoidal hypophysectomy between November 1972 and January 1980. No patient required a tracheostomy. Oral tracheal intubation with the fiberoptic bronchoscope was required in six patients, four on an elective basis (topical anesthesia, intravenous sedation) and two because previous attempts at direct laryngoscopy had been unsuccessful. In our institution difficulty of endotracheal intubation is graded on a scale of 0–1–2, 2 indicating marked difficulty in visualizing and intubating the trachea. In the 88 patients not requiring fiberoptic endotracheal intubation, difficulty of intubation was graded 0 in 55 patients, 1 in 27 patients, and 2 in 6 patients. Thus, our experience does not support the recommendations of Southwick and Katz regarding routine tracheostomy in selected patients.

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Severe Skin Damage from EKG Electrodes

To the Editor:—With improved care in the use of electrocautery, the incidence of electrical burn has decreased; however, it still presents a hazard as illustrated by the following case.

A 50-year-old white woman with no known allergies had surgery performed on her right knee. A dispersive electrocautery electrode (NDH-Silvon) was placed on the left thigh. For cardiac monitoring, EKG electrodes were applied. The anesthesia sequence was thiopental, succinylcholine, and endotracheal administration of enflurane and nitrous oxide; recovery was uneventful.

On the first postoperative day, the three sites where the electrodes were applied showed signs of redness with the precordial area having damaged skin. On the fifth postoperative day, an ulcer had formed, approximately 3 cm in diameter. Its central area showed complete loss of skin and a black eschar. Unlike the precordial area, the central areas on the right and left shoulder showed normal skin; however, there were red circles matching the size and the site of EKG electrode adhesive (fig. 1). Another definite red line with denuded skin showing the adhesive tape marks was noted at the precordium.