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Epidural Block for Chronic Pain Management Facilitated by Field Block

To the Editor:—Peng *et al.*, in their letter¹ concerning the use of field block before epidural and subarachnoid block, have drawn attention to an aspect of technique that also has important application when these blocks are used in chronic pain management. The Pain Management Centre has used this technique for the last 15 years in unmedicated outpatients having a series of epidural blocks for a variety of chronic pain conditions. It is useful at all spinal levels, including the cervical.² Adequate field block is necessary to permit proper relaxation by the patient and enables us to evaluate whether any degree of overreaction to mild stimulation is present. Also, because epidural block is notoriously difficult in the thoracic region and in patients who have had back operations, an adequate block is necessary for humane treatment and to permit the operator to proceed calmly with the technique, secure in the knowledge that, however difficult the procedure, further pain will not be inflicted. This latter aspect is of particular importance when teaching residents who might

otherwise be made more tense and anxious by complaints of pain from the patients.

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REFERENCES

1. Peng ATC, Behar S, Blancato LS: Reduction of postlumbar puncture backache by the use of field block anesthesia prior to lumbar puncture. *ANESTHESIOLOGY* 63:227–228, 1985
2. Catchlove RFH, Braha R: The use of cervical epidural nerve blocks in the management of chronic pain. *Can Anaesth Soc J* 31: 188–191, 1984

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A Simple, Inexpensive Method to Prevent Heel Sores

To the Editor:—I read with interest the letter by Dr. Pither and colleagues.¹ Eighty per cent of all Cesarean sections at this hospital are performed under lumbar epidural analgesia with either 0.5% bupivacaine or 2% lidocaine with adrenaline 1:200,000. Over one-half of these are emergency Cesarean sections. Many of the mothers undergoing emergency Cesarean section have had epidural analgesia for up to 12 hours in labor before arriving for surgery and may then have a further 12 hours' immobility postoperatively.

Observation by the nursing staff of early pressure damage to the heel skin of these mothers led to the introduction in this hospital of a simple, cheap prophylactic measure. Two empty, 1-l intravenous infusion bags are in-

flated with air and spigotted. These then provide air cushions of a suitable size to be placed one under each heel, thus giving relieved pressure on these vulnerable areas for the duration of motor and sensory block.

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REFERENCE

1. Pither CE, Hartrick CJ, Raj PP: Heel sores in association with prolonged epidural analgesia. *ANESTHESIOLOGY* 63:459, 1985

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Intubation Technique—A Health Hazard for the Anesthesiologist

To the Editor:—Anesthesiologists have traditionally used a two-handed approach to endotracheal intubation,

whereby the thumb and index finger of the right hand are used in a scissors-like movement to pry the patient's

mouth open. Most recently, Gurmarnik¹ suggested a modification, which again depends on inserting the anesthesiologist's fingers into the patient's mouth. We wish to express our concern that this technique may expose the intubator to additional unnecessary risk of infection.

It is known that dentists may acquire hepatitis by contact with their patients' saliva. With hepatitis, herpes simplex, and now human T-cell lymphotropic virus type III (HTLV III) becoming endemic in the population, there is all the more reason to abandon this technique. Because most of us would take secretory precautions when dealing with known carriers of these and other potentially transmissible agents, we are at greater risk from the probably much greater population of undiagnosed carriers than from those known to harbor such infections.

Because opening of the mouth in the anesthetized, paralyzed patient is usually easily accomplished by extension of the alanto-occipital joint with the patient's head in the modified Jackson position and because this places the patient's airway in a position anatomically favorable for tracheal intubation, we feel that the inserting of fingers into the patient's mouth should be abandoned. Care must be taken to avoid entrapment of the patient's lower lip between the laryngoscope blade and lower dentition. That

can easily be accomplished by slight caudad pressure on the patient's chin, a maneuver that also helps to open the mouth. If, in a rare case, placement of fingers in the mouth is unavoidable, one should wear gloves, as do our gynecologic and proctologic colleagues when digitally examining the genitalia or rectum. In our hospital we now stock single-use nonsterile gloves in the anesthesia carts.

By the same token, the routine daily use of either prescription eyeglasses or plain glass spectacles during the conduct of anesthesia should probably be encouraged to avoid the risk of inoculation of our conjunctiva with potentially infectious airborne saliva or blood.

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REFERENCE

1. Gurmarnik, S: Can traditional intubation be modified? *ANESTHESIOLOGY* 63:464, 1985

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Solving a Difficult Intubation

To the Editor:—When a difficult or impossible oral tracheal intubation arises and the directly visualized oral approach is unsuccessful, alternative techniques include blind nasal, retrograde, and fiberoptic-assisted. We report the use of these techniques combined.¹

A 48-yr-old, 90-kg man scheduled for coronary artery bypass surgery was anesthetized with nitroglycerin, iv, pancuronium bromide, 10 mg, and fentanyl, 50 µg/kg. Ventilation was controlled, and $F_{I_{O_2}}$ was 1.0.

Oral endotracheal intubation attempts with Macintosh® #3 and #4 and Miller® #2 and #3 blades^{2,3} were unsuccessful because we could not visualize the vocal cords. Attempts at blind oral and nasal intubation also failed. A fiberoptic bronchoscope was then used⁴ but was impossible to insert because the trachea was too anterior. A 16-g needle was placed through the cricothyroid membrane into the trachea.⁵ An angiography catheter exchange guide wire (260 cm length and 0.035 in diameter) was directed cephalad through the needle and retrieved from the pharynx with forceps. Two more attempts to pass the endotracheal tube (8.0 mm ID, National Catheter Co.) over the wire were unsuccessful. We then placed the endotracheal tube over the fiberoptic bronchoscope and threaded the angiography wire retrograde through the

suction port of the scope. We were able to direct the fiberoptic bronchoscope into the trachea and subsequently slide the endotracheal tube into position above the carina. It took 35 min from the time of induction to accomplish the intubation.

This combined new technique for difficult intubation may be preferable to tracheostomy as long as ventilation and hemodynamics are stable during intubation efforts. Anticipated complications are the same as with any technique that risks cricothyroid membrane puncture. This modification may be preferred to retrograde technique because tube placement is confirmed by direct visualization.

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