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### Advice to the Patient with a Difficult Airway

*To the Editor:*—The review article by Benumof<sup>1</sup> describing in detail the management of the patient with the difficult airway is an excellent and comprehensive analysis of preoperative and intraoperative considerations, but it ignores the postoperative period. In my opinion, our responsibility to patients with this problem does not end with the discharge of the patient from the recovery room. This is not a trivial point. If a patient with an unanticipated difficult airway presents for surgery and after much difficulty the anesthesiologist achieves control of the airway, and if that same patient presents at another hospital at a later date and the same thing happens (or maybe worse), a disservice was done to that patient.

Whenever I have had a patient with a truly difficult unrecognized airway problem, I have made it my practice to talk to the patient postoperatively and give him or her a letter describing in detail what happened, with instructions that if surgery is ever necessary again to be sure to give the letter to the anesthesiologist. Some of my colleagues have even suggested that these patients acquire a medical alert bracelet.

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### Tracheal Extubation

*To the Editor:*—For routine extubation, Benumof<sup>1</sup> recommends “the patient should breathe 100% oxygen for 2–5 min. Just prior to extubation, the patient should be given a large sustained inflation; while the lung is near total lung capacity, the endotracheal tube cuff should be deflated and the endotracheal tube pulled simultaneously.” The technique described above involves at least three simultaneous tasks being done with two hands. This sequence is easier said than done, particularly by the novice trainee.

We have found the “passive cough technique” is a more consistent way of achieving the same objective and can be easily taught to the trainee. We recommend: 1) The patient breathe oxygen at a high flow (10–12 l/min) for 2–5 min. 2) The pop-off valve is closed. 3) Administer one or two large breaths. 4) When the intrathoracic pressure has risen to 5–10 cmH<sub>2</sub>O (usually takes less than 10 s), the cuff is deflated and the trachea extubated. This will ensure both a passive cough and a greater certainty that the airway and vocal cords are cleared of secretions.

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### A Valuable Alternative for Laryngeal Visualization of the Difficult Airway

*To the Editor:*—A forgotten instrument for easier visualization of the glottic opening during difficult intubations (not mentioned in a recent review<sup>1</sup>) is the Jackson anterior commissure laryngoscope (or Holinger's modification<sup>2</sup>) routinely used by otolaryngologists—head and neck surgeons. Anecdotal references suggest that when the regular laryngoscope blades fail to provide good vision, an otolaryngology scope allows better access. We have used the scope several times for both

adults and children. This case describes our most recent use of the scope, which we believe should be used more often.

A 67-yr-old, 136-kg patient with a recurrent nasal basal cancer (large ulcerative lesion involving cartilages and bone) was scheduled for partial rhinectomy, maxillectomy, and cheek rotation flap. Preoperative assessment showed a supple neck and face, a limited airway opening, and a class IV Mallampati score. The patient reported undergoing a

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