

Airway management in Ludwig's angina: what is necessary and what is sufficient condition?



Manejo das vias aéreas em angina de Ludwig: o que é necessário e qual é a condição adequada?

Dear Editor,

I've followed the topic of "Airway management in Ludwig's angina" in your valuable journal. As Fellini et al.¹ described, decision making regarding airway management in such a disastrous situation will be based on clinical feature, urgency of the case, and technical availability. There is a rule in our routine practice as anesthesiologists: there is not the safest anesthetic agent, nor the safest anesthetic technique; there is only safest anesthesiologist! So being an expert anesthesiologist is the necessary condition, but not sufficient, for making a best decision for airway management in patients with compromised airway. Maintaining spontaneous breathing is a key element in airway management of a patient with compromised airway. Accordingly, when I read a letter of Guedes, I understood that the situation must have been completely different.² Co-administration of clonidine, fentanyl and midazolam may put the patient at risk of collapsing the airway. Because "you cannot fight the success", successful airway management in this patient can imply that the best person who can make the best decision about the pa-

tient is the one who is at the bedside. In other words, being in the scene is the sufficient condition for making the best decision regarding airway management method in patients with Ludwig's angina or any other kind of compromised airway.

Conflicts of interest

The author declares no conflicts of interest.

References

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2. Guedes AA. Airway management in Ludwig's angina – a challenge: case report. *Braz J Anesthesiol.* 2018;68:661.

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Relevance of single-lumen endotracheal tube diameter and type of bronchial blocker for lung isolation in an emergent case



Relevância do diâmetro do tubo endotraqueal de único lúmen e do tipo de bloqueador brônquico para o isolamento pulmonar em um caso de emergência

Dear Editor,

We would like to add some comments to the clarification that Grocott¹ provided about the published paper by Almeida et al.,² "Use of bronchial blocker in emergent thoracotomy in presence of upper airway hemorrhage, and cervical spine fracture: a difficult decision".

In the reported case, the exchange of the Single-Lumen endotracheal Tube (SLT) to a larger diameter tube may be advisable.

Grocott¹ reminded the readers that the minimum diameter ETT to perform lung isolation with an EZ Blocker™ Teleflex, Morrisville, USA, under fiberoptic visualization is considered 7 mm. In this case, a thin bronchoscope Ambu aS-

cope S slim 3.8/1.2™, Ambu A/S, Ballerup, Denmark (outer diameter: 3.8 mm) was used, which would allow simultaneous use of the EZ Blocker™ through the SLT.

Nevertheless, during initial placement, verification of position and eventual repositioning of the Bronchial Blocker (BB) under bronchoscopy, a tube with a larger diameter than 7 mm will allow better ventilation. Because the free lumen of the tube that remains available for gas flow is larger.

Considering the condition of the patient, it was a valuable option to exchange the SLT from a 7 mm to 8 mm. Moreover, the fact that the minimum diameter of tube needed is 7 mm to place an EZ-Blocker™ does not imply that larger tubes cannot be used if a small diameter fiberscope is not available.

The exchange, considering the benefit-risk ratio, may be performed very quickly after careful aspiration of the oropharynx, without extension of the head, which will not provoke significant blood entry into the trachea from tongue bleeding.

As it was explained in the paper by Almeida et al.,² at initiation the patient did not have endobronchial hemorrhage (only significant tongue hemorrhage). It was not present during the first positioning of the bronchial blocker, but throughout the case due to the surgical manipulation and aggravation of the coagulopathy.