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Anticipation and Management of the Emergency Airway in the Cosmetic Patient during Office-Based Surgery

Sir:

With the number of cosmetic surgical procedures continuing to rise and a growing percentage being performed in the office-based setting, scrutiny by regulators and state licensing agencies has also increased.[1] The *U.S. News and World Report* stated that the office-based setting is associated with a 10-fold increase in the risk for serious injury or death.[2] Recognizing safety as a top priority, in 2002 the American Society of Plastic Surgeons Board of Directors convened the Task Force on Patient Safety in Office-Based Surgery Facilities. One aspect of surgical safety in which the surgeon typically has little participation until faced with a catastrophe is anesthesia induction and airway intubation.

Historically, three pathways have been considered with difficult airways: (1) bag-mask ventilation and reversal of sedatives and paralyzing agents, (2) extratracheal ventilation using a laryngeal mask airway or esophagotracheal combination tube, and (3) an emergent surgical airway.

Although each of these options carries value, they all have potential pitfalls and shortcomings.

Bag-mask ventilation and sedation reversal is not possible in many instances, and its endpoint is an aborted procedure. The laryngeal mask airway may not perform well with an obstructing tumor or with heavy secretions. The esophagotracheal combination tube should not be used in patients with an intact gag reflex, children (patients younger than 16 years), or patients with proximal esophageal disease.[3] Surgical access through the neck may be impossible because of obstructing neck tumors or anatomical abnormalities such as severe cervical flexion.[4] Postoperative ramifications of stomal care, speech and swallow rehabilitation, psychological stress, and an inconspicuous scar must also be considered.

As an alternative, we introduce a fourth option, the anterior commissure laryngoscope. Once familiar with its application, the surgeon usually can advance the laryngoscope at least to the posterior glottis and use it as a guide for intubation.[4] The laryngoscope has a straight enclosed barrel that prevents the tongue from being obscured and allows easy suctioning. Its shape and design have better leverage capabilities than standard blades. The distal end is flared anteriorly, with a recessed light permitting a good view of the larynx (Fig. 1).[5]

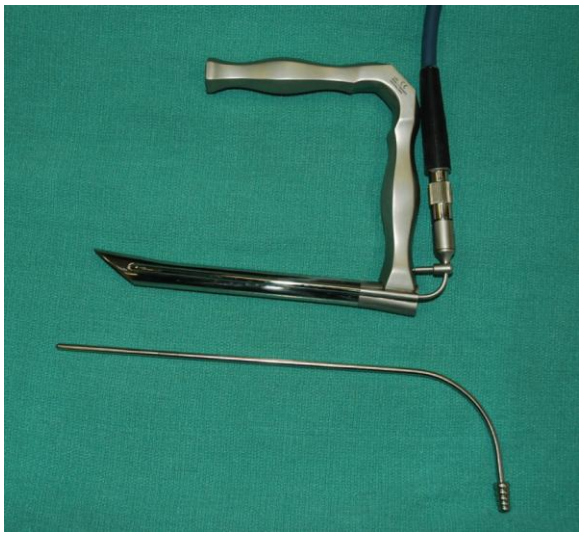

Fig. 1. The anterior commissure laryngoscope.

The laryngoscope is passed from the right corner of the mouth, displacing the tongue leftward, and advanced toward the larynx between the tongue and the tonsil. Once vocal cords are visualized, a lubricated gum bougie or an adult Cook airway catheter (Cook Medical, Inc., Bloomington, Ind.) is advanced through the enclosed barrel (Fig. 2). The bougie or catheter is manually held in position while the laryngoscope is removed. The endotracheal tube can then be advanced into position using the Seldinger technique, analogous to advancing a central venous catheter over a guidewire.

Fig. 2. The bougie is advanced through the laryngoscope.

Management of the emergent airway allows little room for error. Because there are instances when traditional
management of emergent airways will not be successful, it is important that the surgeon know how to
use an anterior commissure laryngoscope to avoid catastrophe.
It is the duty of any surgeon to ensure patient safety, and appropriate accreditation, safe anesthesia protocols, and proper patient selection constitute the basis for safe and efficacious office-based surgery.[6]

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