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Reluctance of anaesthetists to perform awake intubation

A survey I conducted in the Oxford region showed that 57% of consultants would not do an awake fibre-optic intubation (FOI) as their first option to secure the airway when dealing with a patient awoken by an SHO following a rapid sequence induction (RSI) and failed intubation. It is difficult to gain experience in awake FOI as a trainee and this is due to limited clinical indications and because anaesthetists often opt for alternative methods of intubation.

Some anaesthetists feel they lack the training and experience or have become deskilled in awake FOI. Consequently, choosing a technique they are familiar with may be safer and more successful. Preparing and performing an awake FOI takes more time than repeating a RSI. However, this delay should be limited to no more than 30 min. We all have a responsibility to provide training [1], even if performing a technique for teaching purposes may take longer. Of course, if one fails to intubate when repeating an RSI the delay will increase. It may be argued that awake FOI is not the only skill we need when dealing with a potential difficult intubation. However, the alternatives such as the LMA-Proseal™ (LMA North America, Inc., San Diego, CA, USA), intubating LMA™ (Intavent Orthofix Ltd, Maidenhead, UK), blind nasal intubation, asleep fibre-optic intubation, inhalational induction with cricoid pressure and regional anaesthesia, can all be practiced on routine theatre lists.

Of those consultants choosing an RSI or alternative method, 76% thought that awake FOI was an unpleasant experience for the patient, although 53% felt comfortable with the technique. Many trainees will be familiar with the sight of a patient coughing during fibre-optic laryngoscopy, going cross-eyed as the tracheal tube is passed through the nose and virtually leaping off the bed as it passes the cords, their distress only being relieved by an induction dose of propofol. However, we know that even in unsedated volunteers, awake FOI can be performed without distress and can even be an enjoyable experience [2]. As someone who has had an awake FOI without sedation I can verify this. With good topical anaesthesia awake FOI can be made comfortable. I suspect that the teaching and use of appropriate local anaesthesia of the airway would increase acceptance of awake FOI by anaesthetists, encourage regular practice of the technique and finally dispel the myth surrounding it. Maybe then trainee exposure to this procedure will increase.

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Dystonic reaction to cyclizine

We report a further case of dystonic reaction following cyclizine. A 72 year-old male underwent varicose vein surgery. Previous general anaesthesia had been uneventful. His past medical history included a single episode of epilepsy treated with carbamazepine. There were no further fits. He had hypertension treated with enalapril and bendrofluazide, and he was also taking simvastatin, aspirin, timolol and coproxamol. He had no known drug allergies.

Induction of anaesthesia was achieved with propofol and fentanyl and a laryngeal mask airway was inserted. Anaesthesia was maintained with oxygen, nitrous oxide and isoflurane. Other drugs administered during the procedure included cyclizine, glycopyrronium and rectal diclofenac. Following surgery the patient was transferred to the recovery area. Thirty minutes later he was awake, well oxygenated and haemodynamically stable, but confused and disorientated. A neurological examination revealed spontaneous eye-opening, no speech, localising to painful stimuli, significant muscle rigidity and periodic opisthotonus. A presumptive diagnosis of dystonic reaction to cyclizine was made and two doses of benzatropine (2 mg iv, each) were administered. Over the following 30 min he became more responsive, less rigid and the opisthotonus resolved. The following morning he was symptom free and had no recollection of any neurological symptoms. He was subsequently discharged home.

Although the incidence of dystonic reactions to cyclizine is thought to be low there have been a number of reports recently [1–3] and further reports may lead to the suggestion that they are more common in patients with central neurological disease.

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