CR#21

Airtraq In severe ankylosing spondylitis

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Basaranoglu G, et Al. Vakif Gureba Education and Teaching Hospital, Istanbul,

We would like to report the successful use of the Airtraq as a rescue device following failed awake fibreoptic intubation in a patient with ankylosing spondylitis (AS).

A 48-yr-old male with a BMI of 32.5 and a long history of ankylosing spondylitis was admitted for elective nephrolithotomy. Physical examination revealed an immobile neck, head extension fixed at 150° and a Mallampati Class II airway. **Lateral X-Ray confirmed widespread cervical ankylosis.**

A regional anaesthetic technique was excluded due to patient choice, so an awake fibreoptic intubation was planned followed by general anaesthesia. An antisialogogue (atropine 500mcg) was given and small boluses of intravenous midazolam were titrated to response (2.5mg). Following a standard technique to topically anaesthetise the airway using lidocaine (100 mg), **fibreoptic endoscopy was attempted but the intubation was unsuccessful due to mechanical failure of the endoscope**. Anaesthesia was then induced using a bolus of propofol (1mg/kg) and an uncomplicated intubation (size 8.0mm endotracheal tube) was achieved using the Airtraq laryngoscope.

In experienced hands awake fibreoptic intubation is often the best option for securing the airway in patients with difficult airways, e.g. ankylosing spondylitis [2] though the technique does have a low failure rate. **Both the fibrescope and the Airtraq laryngoscope can provide a full indirect view of the glottis without the need for anatomical alignment [3]. However, intubation proficiency with the Airtraq can be achieved quickly and it has a shorter learning curve that fibreoptic endoscopy.**