Nasopharyngeal airway as a diagnostic and therapeutic tool in difficult airway

Sir,

We read with great interest the article written by Kundra and Parida.[1] The article is thought provoking and nicely written. Although we agree with each of the points contributed by the authors regarding the utility of prior insertion of nasopharyngeal airway (NPA) in an anticipated difficult airway (mask ventilation in particular), we felt that a couple of additional points may be considered.

Every effort should be made to obtain best preoxygenation using techniques such as application of positive end expiratory pressure (or continuous positive airway pressure), 15°-20° head-up tilt or both.[2] However, the drawback of preoxygenation is that it will not provide additional oxygenation during intubation attempts. In a known case of difficult or anticipated difficult airway, efforts should be made to provide oxygenation prior to as well as during intubation attempts. Use of high flow oxygen through nasal catheters for oxygenation during the period of laryngoscopy has been proven to enhance the safe duration of apnoea compared to conventional laryngoscopy.[3,4] Authors in the present article lay emphasis on prior insertion of an appropriate sized NPA to appropriate depth which can resolve many issues that might otherwise occur at a latter point of time after induction and is a welcome move.[1] We suggest based on literature evidence that if oxygenation is continued through this preinserted NPA during attempts at laryngoscopy, it may further enhance patient safety. A tracheal tube connector, which snugly fits into the NPA lumen, permits the breathing circuit to be directly connected to the NPA for this purpose. This simple step may reduce the stress on the person handling the airway.

Another point that we want to suggest is based on our personal experience. When a NPA is already present prior to induction in an anticipated or known difficult airway, we have used it as a conduit for flexible (paediatric) fibreoptic evaluation of the larynx and its surrounding structures prior to induction. Several of these patients had undergone radiation to head and neck or had malignancy in or around the laryngeal area. The information gleaned by fibrescopic evaluation (when it revealed a normal looking airway or minimal evidence of pathology) had helped us proceed safely to airway control following induction as opposed to the original plan of awake intubation. Since the NPA is confirmed to be appropriately placed by breath sounds and capnograph, an appropriate size flexible fiberscope passed through this directly visualises the glottis in most instances. Therefore, a check fibrescopic evaluation can be done in a totally atraumatic way as this passes through an already existent NPA. Further, it does not require additional anaesthesia or sedation as it does not add to patient discomfort.

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