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LETTER TO THE EDITOR

Airway management in Ludwig's angina – a challenge: case report

Manejo da via aérea na angina de Ludwig – um desafio: relato de caso

Dear Editor,

I read with interest the case report described by Fellini et al.[1] I congratulate the authors for the case reported. In fact, a successful airway management in Ludwig's angina (LA) can be challenging. Tracheal intubation is the gold standard for airway management, and awake intubation with the patient in spontaneous ventilation provides safety to patients with difficult airways.[2]

Coincidentally, two days after reading the case report, I was called to evaluate a female patient, 27 years old, crack user, with a diagnosis of LA caused by an extensive odontogenic infection and indication for urgent drainage. The physical examination in my case differed in some respects: the patient had no subcutaneous emphysema, stridor, mediastinal impairment, signs and symptoms of acute airway obstruction, or acute respiratory failure at the preanesthetic visit.

Our approach differed somewhat from that of Fellini et al. First, after conscious sedation with clonidine, fentanyl and midazolam, we performed a superior (bilateral) and inferior (transtracheal route) laryngeal nerve block guided by ultrasound to identify the landmarks. After obtaining a minimal mouth opening, we inserted a bite block and instilled lidocaine in the oropharynx, with the aid of a proper atomizer. Second, after the procedure, we decided to extubate the patient. This decision was based on the physical and also endoscopic examination of the airways during the flexible bronchofibroscopy (BF), which was normal. Previously, however, we inserted a tube exchanger into the tracheal tube, which was removed 20 min after extubation.

Differently from the authors, we opted for oral intubation because, with the use of BF, the nasal route may be prone to complications,[3] particularly in cases of LA.

In the case reported by Fellini et al., signs of acute airway obstruction, respiratory failure and hypoxemia were evident. We believe that the use of BF is not suitable for emergency situations.[2] Perhaps a surgical airway access should have been the first option, since the technique employed by the authors was successful, but it could have evolved into a disaster. We disagree with the authors regarding the use of other methods, such as videolaryngoscopes, because in those cases where mouth opening is minimal or nonexistent these tools would be of little value.[2] Surgical access is not a method to be avoided at all costs.

Finally, the challenging cases of airway management require the mastery of all available techniques that, together with the careful preoperative evaluation, allow the best outcomes.

Conflicts of interest

The author declares no conflicts of interest.

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