can not comment on the total opioid requirement during the surgery. Pin manipulation in neurosurgical patients is always done under local anaesthetics. Other limitations include nonmeasurement of plasma levels of the induction agent. In such study proper binding of the personnel and procedures poses a real problem.

In conclusion, the present study shows the usefulness of McCoy laryngoscope in maintaining the haemodynamics near baseline and the use of fentanyl can be avoided. This corollary may further be extended to minimize the usage of other drugs to attenuate the haemodynamic responses to laryngoscopy and intubation. The findings of this study need to be confirmed by more prospective studies.

References


Hemodynamic Changes During Laryngoscopy: Does it Matter?

The article convincingly demonstrates in a large group of patients that, when tracheal intubation is not difficult, laryngoscopy is less stressful with the McCoy laryngoscope than with the classical MacIntosh blade, allowing to use less fentanyl for laryngoscopy.

Are short-term changes in blood pressure clinically relevant in ASA I–II patients undergoing elective surgery? Is it interesting to use 2 µg/kg less fentanyl for elective neurosurgical patients during anesthesia? The answer is probably no for both questions! So, what does this study mean and why are there so many studies on the hemodynamic changes associated with tracheal intubation? Because anesthetic management is not so easy in the real world. Certainly every anesthesiologist has seen large drops in blood pressure with the association of low doses fentanyl and thiopental for induction of anesthesia in emergency or unstable patients. It is also not rare to observe unpredictable severe hypertension after laryngoscopy. In a few patients, both hypotension and hypertension may have disastrous consequences. This is especially true for emergency neurosurgery.

Aneurysm rupture has been reported as a consequence of hypertension during tracheal intubation.14 But hypertension in patients with intracranial hypertension may critically decrease cerebral perfusion pressure leading to cerebral ischemia. Hemodynamic stability and prevention of hypertensive events are also critical for the management of acute aortic dissection2 or in patients with severe coronary artery disease.15 Thus, it is clear that in some patients hemodynamic stability during induction of anesthesia and tracheal intubation is both desirable and difficult to achieve. By decreasing the amount of anesthetic agents necessary to perform laryngoscopy, the McCoy laryngoscope may be a simple and valuable tool in difficult hemodynamic situations.

However, this study has several limitations. First, the authors excluded patients with difficult intubation. As the pressure applied to the laryngoscope increases, the difference between laryngoscopes will probably disappear. Second, the authors did not measure the duration of laryngoscopy, a factor, which has been shown to be closely related to the pressure response.
Finally, this study opens new prospects. It is reasonable to assume that a less painful laryngoscopy, would improve the quality of intubation particularly when it is desirable to avoid neuromuscular blockers. It seems clear that the quality of intubation contributes to laryngeal morbidity.\[4,5\] It has to be demonstrated whether or not the McCoy laryngoscope is able to decrease airway injury.

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