“PUSH” as a mnemonic for Modified Mallampati classification

Dear Editor,

Mallampati classification is an important airway assessment tool that is often used. It has been used with limited discriminative power for difficult tracheal intubation. It is a simple, reproducible, and reliable pre-anesthetic airway assessment method when performed properly. Modified Mallampati classification was defined by Samsoon and Young in 1987 and they mentioned 4 grades according to the anatomical structures. They modified the classification given by Mallampati et al. and used it as assessment tool of difficult intubation. Samsoon classified it as Grade 1: Faucial Pillars, Uvula, Soft palate, Hard palate; Grade 2: Uvula, Soft palate, Hard palate; Grade 3: Soft palate, Hard palate; Grade 4: Hard palate only.

This classification is used in each and every patient as an effective airway assessment tool. The components of Mallampati classification are ought to know by all the undergraduate, post graduate students, technical staff, and anesthesiologists. A mnemonic device is any learning technique and it aids retention of information or retrieval (remembering) in human memory. Mnemonics helps in fact remembrance and are particularly useful when the order of things is important. It is always time saving, effortless learning, and simple to remember the things.

The authors are medical school teachers and designed a mnemonic for Mallampati Grading, that is helping to all the students to remember it. It is designed as “PUSH”. With each grade, delete one alphabet and finally last will be “H” as grade 4 i.e., Hard palate only (See below and in box).

| Grade 1 | Faucial Pillars, Uvula, Soft palate, Hard palate: PUSH |
| Grade 2 | Uvula, Soft palate, Hard palate: USH |
| Grade 3 | Soft palate, Hard palate: SH |
| Grade 4 | Hard palate only: H |

For last many years, the authors are using this mnemonic in teaching all students and in all airway management forums regularly. As an observation, this mnemonic is easy to learn, reproduce and implement in day-to-day practice of airway assessment and management.

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Dear Editor,

Anaesthesia management of conjoined twins for separation surgery is a challenging task due to the management of two patients simultaneously with their unique physiological changes like crossed circulation, distribution of blood volume and organ sharing. Separation surgery requires meticulous planning with multidisciplinary involvement for a successful outcome. Anaesthesiologist and surgeon have to compromised for positioning of conjoint twins during procedures. Separation surgery is usually long duration surgery with anticipated massive fluid shifts mandating the need for invasive monitoring like central venous and arterial monitoring. We herein discuss the steps undertaken for site selection for successful cannulation for invasive monitoring.

Female pyopagus conjoined twins aged 2 years with a combined weight of 15 kg were planned for separation surgery. Twins had bony fusion from S1 vertebra, the fused spinal cord from L3 onwards and common anal canal. The left twin also had severe scoliosis. Anticipated duration of surgery was 18‑20 hours due to multidisciplinary surgical corrections.

Central venous cannulation was planned for intraoperative hemodynamic monitoring, fluid infusion, medication administration, and blood sampling. We planned ultrasound‑guided internal jugular venous (IJV) cannulation of twins. Initially, due to relative ease of positioning, right IJV cannulation for the right twin and left IJV cannulation for the left twin was planned. As the left IJV cannulation can be difficult, we did ultrasound scanning a day before surgery in the ward to evaluate the optimal position and size of IJV on both sides in conjoint twins. It was noticed that the left twin’s left IJV lumen was relatively small compared to the right IJV and the lumen of the right IJV of right twins was better than the left‑side IJV. It is known that cannulating the vein with larger lumen is easier. We noticed that after positioning,

References

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