Letters to Editor

4. Arisaka H, Sakuraba S, Furuya M, Higuchi K, Yui H, Kiyama S, et al. Application of gum elastic bougie to nasal intubation. Anesth Prog 2010;57:112-3.

5. Inoue H, Saito T, Kamishima K, Okano T, Kuno Y, Arai T, et al. Successful nasal intubation using airway scope with gum elastic bougie in a case of difficult airway. Masui 2008;57:457‑9.

6. Kitano M, Komasawa N, Nakahira J, Fujiwara S, Tatsumi S, Minami T, et al. Successful nasotracheal intubation with the PENTAX-AWS AirwayScope and gum-elastic bougie in a patient with recurrent tongue cancer. Masui 2014;63:409-11.

7. Staar S, Biesler I, Müller D, Pförtner R, Mohr C, Groeben H, et al. Nasotracheal intubation with three indirect laryngoscopes assisted by standard or modified Magill forceps. Anaesthesia 2013;68:467‑71.

8. Abrons RO, Vansickle RA, Ouanes JP. Seldinger technique for nasal intubation: A case series. J Clin Anesth 2016;34:609-11.

9. Abrons RO, Zimmerman MB, El-Hattab YM. Nasotracheal intubation over a bougie vs. non-bougie intubation: A prospective randomised, controlled trial in older children and adults using videolaryngoscopy. Anaesthesia 2017;72:1491-500.

This is an open access article distributed under the terms of the Creative Commons Attribution‑NonCommercial‑ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

How to cite this article: Abrons RO, Loftus RW. Intubation over a bougie: Nasal is not novel. Saudi J Anaesth 2018;12:373‑4.

© 2018 Saudi Journal of Anesthesia | Published by Wolters Kluwer ‑ Medknow

Saviour in a mess: Spinal needle (Gaurav Technique)

Sir,

Epidural is one of the oldest and most common procedures performed by the anesthetist. Various techniques such as loss of resistance to air and saline, hanging drop technique, barracks running infusion with change in electrical conductivity, and dual technique where loss of resistance technique is combined with amplification of sound produced by epidural needle have been described.[1] However, none of the methods is found to be foolproof. Out of all the available methods, blind localization of epidural space with loss of resistance method is still used commonly.[2] Many times finding the epidural space with loss of resistance technique can be very challenging even in the hands of an experienced anesthesiologist. Recently, ultrasound-guided epidural space localization has been described for the difficult spine anatomy. However, its high cost and long learning curve restricts its use in the developing countries like India. Hence, we present a unique technique as an additional tool for localization of epidural space by blind technique, wherein a spinal needle with the markings for the depth estimation was used for the localization of epidural space.

In this technique, first of all 27 g spinal needle is marked at different levels with the sterile marker to give us the depth estimation [Figure 1]. Then, it is helded and introduced in the same manner as for giving spinal anesthesia [Figure 2a]. The spinal needle is introduced until the feel of ligamentum flavum can be appreciated. The spinal needle is then left in situ. Now 18 g tuohys epidural needle is inserted right along the spinal needle trajectory [Figure 2b]. Using loss of resistance technique epidural space is located [Figure 2c]. Epidural catheter is inserted, and needle is railroaded over the catheter, while still the spinal needle is in situ [Figure 2d]. After giving test dose and confirming catheter location, spinal needle is taken out, and epidural catheter is secured with Tegaderm dressing and micropore.

Most of the time securing the epidural in obese patients requires multiple relocalization of the large 18 g epidural needle, giving a lot of discomfort to the patient and thus increasing the vasovagal chances. At the same time, it also increases dura puncture chances by epidural needle. It is easy to understand that discomfort produced by the multiple

Figure 1: Spinal needle along with the sterile marker and scale
relocalization of spinal needle can be far less when compared to the epidural needle. Some of the anesthetist uses 1½ inch long needle as a finder needle before inserting the epidural needle. Many times 1½ inch long needle is not long enough to bypass the bony hindrances in localizing the deep epidural space in obese patients. While at other times 26 g 1½ inch long needle can easily puncture the dura where epidural space is superficial. There have been cases where epidural catheter is inserted accidentally into the subarachnoid space after the dura has been punctured with 26 g 1½ inch long needle.\(^3\) We had put the markings on the spinal needle to estimate its depth, therefore, when epidural needle is inserted right along the spinal needle trajectory one can easily know how much epidural needle is needed to be inserted to reach the epidural space. The obvious limitation of our technique is the need of expertise in spinal anesthesia. To conclude this technique can be used as an additional tool to blind localization of epidural insertion especially in obese patients where it usually requires multiple attempts. However, we suggest large randomized clinical trials before this technique can be widely accepted.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Gaurav Sindwani, Aditi Suri\(^1\)
Department of Anesthesia, ILBS, \(^1\)Department of Anesthesia, All India Institute of Medical Sciences, New Delhi, India

Address for correspondence:
Dr. Gaurav Sindwani,
Department of Anesthesia, ILBS, New Delhi - 110 070, India.
E-mail: drsindwani25@gmail.com

References
1. Singhal S, Bala M, Kaur K. Identification of epidural space using loss of resistance syringe, infusion drip, and balloon technique: A comparative study. Saudi J Anaesth 2014;8:S41-5.
2. Wantman A, Hancox N, Howell PR. Techniques for identifying the epidural space: A survey of practice amongst anaesthetists in the UK. Anaesthesia 2006;61:370-5.
3. Tandon M, Pandey CK. No rent is small for migration of epidural catheter into sub-arachnoid space. Indian J Anaesth 2015;59:133-5.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Access this article online

| Website: | Quick Response Code |
|----------|---------------------|
| www.saudija.org | ![QR Code](https://example.com/qr-code.png) |

DOI: 10.4103/sja.SJA_4_18

How to cite this article: Sindwani G, Suri A. Saviour in a mess: Spinal needle (Gaurav Technique). Saudi J Anaesth 2018;12:374-5.

© 2018 Saudi Journal of Anesthesia | Published by Wolters Kluwer - Medknow