Difficult laryngoscopy and tracheal intubation: observational study

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Abstract

Introduction: Since anesthesia complications associated with unexpected difficult airway are potentially catastrophic, they should be avoided. The modified Mallampati test and jaw-thrust maneuver enable the identification of difficult airway. The aim of this study was to associate the modified Mallampati test and the jaw-thrust maneuver with laryngoscopy (Cormack–Lehane) in an attempt to identify a better predictor of difficult airway in an adult population undergoing elective surgery.

Method: A cross-sectional study in which 133 adult patients undergoing elective surgery requiring tracheal intubation were analyzed. The accuracy and specificity of the modified Mallampati test and jaw-thrust maneuver were assessed by correlating them with difficult laryngoscopy (Cormack–Lehane Degrees 3 and 4).

Results: In the 133 patients evaluated the difficult intubation rate found was 0.8%; there was association between the two predictive tests proposed ($p = 0.012$). The values of 94.5\% for specificity and 95.4\% for accuracy were found for the jaw-thrust maneuver and for the modified Mallampati test, the values found were 81.1\% and 81.2\%, respectively. Kappa agreement identified a result of 0.240 between jaw-thrust maneuver and Cormack–Lehane, which was considered reasonable. On the other hand, a poor agreement ($\kappa = 0.06$) was seen between modified Mallampati test and Cormack–Lehane test.
Introduction

Airway management remains a major challenge for anesthesiologists. Although advances in the development of new airway devices and well-defined algorithms that guide the approach in emergency situations have reduced difficult airway complications, there has been little change regarding difficult airway predictors, which are essential for the adequate use of these protocols.

Laryngoscopy and tracheal intubation are one of the pillars in airway management during general anesthesia and usually are uneventfully performed. However, if tracheal intubation is difficult or impossible after induction of anesthesia, there may be soft tissue injury, trauma and consequent airway edema, dental avulsion, unnecessary surgical airway, inability to maintain tissue oxygenation, brain injury, cardiorespiratory arrest, and even death. It is worth noting that anesthetic complications associated with unexpected difficult airway, although potentially catastrophic, may be avoided.

Conclusion: The jaw-thrust maneuver presented superior accuracy and agreement than the modified Mallampati test, showing the ability to identify a difficult airway. It is necessary to emphasize the association of tests in the evaluation of patients, emphasizing their complementarity to minimize the negative consequences of repeated laryngoscopies.

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Considering the above, since the inability to maintain airway patency after induction of general anesthesia is an important cause of morbidity and mortality related to anesthesia,\(^2\) it is necessary to investigate options of easy execution, good sensitivity and specificity in predicting difficulty laryngoscopy and tracheal intubation.

Therefore, this study aimed to associate MMT with JTM and try to identify a better difficult airway predictor in adult population undergoing elective surgery at IMIP, as well as to correlate the anesthesiologist’s experience with the degree of difficult laryngoscopy.

**Method**

A prospective, descriptive, observational study was conducted involving adults undergoing elective surgeries at the *Instituto de Medicina Integral Professor Fernando Figueira* (IMIP) surgical clinics. After obtaining the Human Research Ethics Committee approval (CAAE No. 47849915.7.0000.5201), the patients were duly informed about the study.

Thus, all patients older than 18 years, physical status ASA I, II or III, who required general anesthesia and orotracheal intubation were included after given written informed consent. Patients undergoing emergency surgery, with a full stomach, tracheostomized, with severe pulmonary diseases, and those not receiving neuromuscular blockers (NMB) for anesthetic induction were excluded.

For sample size calculation, a simple random sample with variance of 5.6, 95% confidence interval, and 0.9 margin of error was used (Fig. 1, equation). A value of 10% was assumed for any losses and the total number of patients was equal to 133.

Data were collected from November 2015 to January 2016. During pre-anesthetic evaluation, a questionnaire was applied to eligible patients and their airways were carefully examined, including measurement of the interincisal and thyromental distances and head extension capacity. In addition, JTM was performed, which consists of the patient’s ability to lift the chin or, simply, bite the upper lip with the lower dental arch. Modified Mallampati test was performed and classes 3 and 4 were characterized as possible difficult airway predictors.

Anesthetic induction was performed by the anesthesiologist responsible for the procedure based on patient’s clinical indications. However, the use of olfactory position was standardized to allow a better view of vocal chords during orotracheal intubation and rocuronium infusion (0.6 mg·kg\(^{-1}\)). Laryngoscopy was performed two minutes (min) after the neuromuscular blocker administration in order to provide adequate relaxation. In addition, it was established that patients whose MMT classification was 3 or 4 would have the first intubation attempt performed by the most experienced resident or anesthesiologist in the room.

After induction, laryngoscopy was performed and patients were classified according to Cormack–Lehane classification. Difficult laryngoscopy was considered as Cormack–Lehane Grade 3 or 4 or more than 3 attempts for tracheal intubation. The experience time (years) of the physician who performed the intubation and the number of attempts were also recorded.

The study data were collected between November 2015 and January 2016. Statistical analysis was performed using Stata 10.0 software (College Station, Tex). Initially, frequency distribution tables of the assessed variables were constructed and mean and standard deviations were calculated for continuous variables. To calculate the association between categorical variables, a bivariate analysis was performed, chi-square test or Fisher’s exact test was used when indicated, and a significance level of 95% was used.

**Results**

A total of 133 patients, whose demographic and clinical characteristics are shown in Table 1 were assessed. Regarding the age group, the studied population was mostly composed of young adults. It is also observed a predominance of female, as well as a homogeneity regarding physical status (ASA).

Table 2 shows the prevalence of predictors for difficult airway in the study population, as well as the outcomes. There was a low incidence of difficult laryngoscopy and difficult intubation, both with values of 0.8%.

It is also important to note that 23 (19.6%) patients had MMT Class 3 or 4. Regarding jaw thrust, only seven patients (5.3%) could not perform such maneuver. These two were the main predictors of difficult intubation. Regarding Cormack–Lehane classification, no patient was classified as Cormack–Lehane Grade 3 and only one patient (0.8%) was classified as Grade 4. As defined previously, a difficult laryngoscopy rate of 0.8% was found in the present study.

When correlating anesthesiologists’ experience with MMT, ability to jaw thrust, and number of attempts to perform intubation, there was an association with MMT with a significant p-value of 0.004 (Table 3). Therefore, the more experienced the professional, the smaller the number of attempts required.

### Table 1 Sample characteristics.

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<td>Age (years)</td>
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<tr>
<td>&lt;65</td>
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<td>≥65</td>
<td>30</td>
<td>22.6</td>
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<tr>
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<tr>
<td>Female</td>
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<td>67.7</td>
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<tr>
<td>ASA(^a)</td>
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<tr>
<td>1</td>
<td>43</td>
<td>32.7</td>
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<td>2</td>
<td>43</td>
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<td>3</td>
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\(^a\) American Society of Anesthesiologists.
When correlating MMT with JTM, the two assessed difficult airway predictors, there was a significant correlation \( p = 0.012 \) (Table 4).

In this prospective study, the values of true positives, false positives, true negatives, false negatives, accuracy, sensitivity, specificity, and positive and negative predictive values are shown in Table 5.

Analysis of concordance identified a reasonable agreement between JTM and Cormack. Agreement is weak between MMT and Cormack, as well as between JTM and MMT (Table 6).

**Discussion**

Strategies to obtain better conditions for intubation are proven to be effective, such as direct laryngoscopy with the classic olfactory position, and an adequate degree of muscle relaxation, which guarantee optimum visibility conditions. An adequate airway physical examination for predictors that may alert to a possible difficult airway is very useful in preanesthetic evaluation.3,8

However, the search for a predictor that is easy to perform, has good reproducibility, high specificity and particularly high sensitivity to evaluate the airway and is able to independently predict difficult airway reliably is not yet a reality.3

In a multicenter study that guided the evaluation of airway evaluating 492,239 anesthetic inductions, the incidence of difficult airway was 5.8%.9 On the other hand, our study found a low incidence of difficult airway (about 0.8%), which can be justified by the greater anesthesiologist attention to patient positioning, motivated by the investigator’s presence in the operating room. In addition, the improved use of neuromuscular blocker to await its peak action, a criterion standardized in this study, may have also contributed to this finding.

Furthermore, it is known that the incidence of difficult airway can be extremely variable, most of the time depending on the classification used in each study.1 Although most published articles use the Cormack–Lehane Grade 3 or 4 classification to define difficult airway, others authors suggest the need for special techniques for intubation, multiple attempts, or even a combination of these events.1,10,11 Not to mention the anthropometric characteristics of populations, as there is an extensive variability between population groups regarding thyromental and sternomental distances, as well as degree of mouth opening, which are believed to justify the discrepancies in difficult airway rates between studies.10

It is known that a professional with more than two years of clinical practice in anesthesia can be considered experienced for intubation12; moreover, this level of professional experience becomes decisive in the correct classification of MMT and adequate management of difficult airway.13 Thus, the positive association between MMT and level of professional experience can be explained by...
the fact that those patients previously identified with possible difficult airway were preferentially directed to the most experienced professionals at the operating room to reduce the chance of intubation failure and complications related to repeated laryngoscopy, such as periglottic edema, hypoxia, and bleeding.  

As expected, a positive correlation was found between MMT and JTM. It was verified that the use of both tests complements for a more accurate anticipation of a difficult airway; therefore, there is no isolated superiority between them, as declared by another author.  

Supporting the findings of an American study in which 300 patients were enrolled, we found that the level of accuracy of JTM was superior to that of MMT, emphasizing the JTM ability to correctly anticipate difficult laryngoscopy. Additionally, JTM showed higher specificity values (94.5%) than MMT (81.1%), a similar result already highlighted in the cited study. It indicates the JTM superior capacity, when present, to adequately eliminate a probable difficulty in intubation compared to MMT (Class 1 and 2).  

It is worth noting that the sensitivity value and, consequently, the NPV, is not reliable due to the absence of false negative events in both tests. This study therefore had limitations because there were no patients with MMT Class 1 or 2 or with absent JTM who had Cormack–Lehane Grade 3 or 4. The absence of false negative patients in both tests compromised the analysis of sensitivity and negative predictive value, as we find overestimated values for such analyzes. These findings can be justified by the small number of participants with difficult airway.  

In line with previous study, we found a higher PPV for ITM (14%) compared to MMT (4%), corroborating the superiority of JTM when properly performed in correctly warding off difficult laryngoscopy.  

In the present study, the agreement evidenced between MMT and Cormack–Lehane was weak. It is demonstrated, therefore, that a difficulty can be found in the adequate visualization of structures through MMT (Class 3 or 4) and, nevertheless, we came across an easy intubation. While the agreement between JTM and Cormack–Lehane was reasonable; it indicated that, from a practical point of view, it is expected that in patients who are able to lift the chin, the laryngoscopy and, consequently intubation will be easy.  

Through this study, it was not possible to prove the safety of non-using MMT due to the lack of reliable data on the sensitivity of the investigated tests. However, the unpredictability of MMT as a single predictor of a possible difficult airway is notorious. Thus, JTM is more specific and accurate for difficult airway identification and presents a higher rate of agreement with Cormack–Lehane classification.  

The limitations of this study are due first to the methodological deficiency of a cross-sectional study. Second, both MMT and JTM lack patients’ collaboration and understanding. It is not uncommon to have difficulties in correctly understanding the instructions related to these tests, involuntary phonation occurs during the modified Mallampati test application, as well as difficulty in performing JTM. In addition to the short time to assess patients’ airway, the absence of neuromuscular blockade monitoring to ensure that all patients had complete blockade at the time of laryngoscopy was another barrier noted in the study.  

The search for a single parameter with high accuracy, good reproducibility, and easy execution persists. A thorough evaluation of the airway should be emphasized for anesthesiologists to become familiar with the studied predictors (MMT and JTM) associated with others proposed in the literature and thus reduce the number of unexpected difficult airway, as well as reduce the negative consequences of a large number of intubation attempts and not predispose patients to unnecessary procedures.  

Conflicts of interest  

The authors declare no conflicts of interest.  

References  