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Case report

An innovative position for anaesthetising the patient with Halo-Pelvic traction

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To the Editor,

Halo-Pelvic traction is used to improve the trunk balance and frontal and sagittal alignment in patients with severe scoliosis [1]. Halo-pelvic traction in situ, provides a physical obstacle impeding access to the airway. Perioperative intubation of these patient's affords time to plan for successful airway intervention. Several varieties of intubation techniques exists, like awake intubation but no one technique has been proved to be superior to others. Awake intubation has not been shown to be superior to asleep intubation. Awake intubation however, requires a cooperative patient [2].

We describe an innovative position for intubating a child with halopelvic traction placed for scolosis correction which has not described elsewhere in the literature. A 6 year old child with halo-pelvic traction, reported in emergency for removal of ingested coin. Child was shifted to operation theatre on wheel chair. Shifting the child on operation table with such a big frame was cumbersum job. Few cushions were required for proper stabilization of the frame on operation table. Head frame was an obstacle for airway management. Orthopedics surgeon was called to unscrew the frame if required in situation of emergency.

Low lying trolley was arranged, front wheels of the wheel chair were lifted and fitted and engaged on that trolley. Anaesthetist sat on the stool in the space between the two handles and both the handles of the chair were supported with her legs (Fig. 1). Legs of the patient were lifted by placing pillow beneath it. In this way near supine position was maintained on a wheel chair with an adjustable head end. After establishing this position mask ventilation and laryngoscopy became very convenient and child was intubated successfully despite the obstacle created by head frame. Coin was successfully removed and patient was shifted to recovery room and child was made to lie down in the same position in recovery room till he became fully alert.

After 1 week same patient was posted for spine correction. Similar position was achieved for intubating the child. Child was intubated with extreme ease and no hurdles. Another option could have been use of awake fibreoptic. Its use requires co-operative patient and we do not expect six years old child to be as co-operative to permit awake fibreoptic intubation. We recommend that above mentioned position can be tried in such difficult situation; however one should be equipped with all emergency gadgets before anaesthetising such patients.

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Figure 1 Child with halo-pelvic traction positioned on wheel chair for induction of anaesthesia.

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