



In reply: Deliberately restricted laryngeal view with GlideScope® video laryngoscope: ramifications for airway research and teaching

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To the Editor,

We thank Drs. Duggan and Brindley for their thoughtful comments regarding our recent article.¹ They raise several important points, which we will address.

We agree completely that direct laryngoscopy and indirect video laryngoscopy (VL) using angulated or hyper-curved blades are different techniques, with different goals for optimal performance. Also, we agree that new definitions outlining an ideal technique are required to advance research and the teaching of airway management with such indirect video laryngoscopes.

We do wish to clarify one point. Drs. Duggan and Brindley summarized our findings in support of a deliberately restricted laryngeal view for faster, easier intubation by stating that “ease of intubation was *inversely* proportional to the quality of the glottic view.” We caution that this is not entirely accurate. Even with indirect VL, laryngeal views can occur (albeit infrequently) that are sufficiently restricted that intubation becomes difficult. We prefer a “Goldilocks” approach to optimal VL, whereby the larynx is neither over-visualized nor under-visualized. With this approach, the laryngoscopist seeks to expose just enough—and no more—of the glottic opening (i.e., a view similar to that achieved with a modified Cormack-Lehane 2a)² to be certain where to direct the endotracheal tube.

With this “not too much, not too little” approach to VL come important considerations for designing future airway research. Studies evaluating VL technique have previously

been criticized for adopting the visualization goals of traditional direct laryngoscopy.³ Despite this warning, work continues to be published that equates higher percentage of glottic opening scores and Cormack-Lehane grade 1 views with optimal VL technique⁴ and/or better equipment performance.⁵ It is likely that a new grading system is necessary. Conceptually, one approach would be to classify VL viewing using a set point of “0” for the ideal, somewhat restricted laryngeal view, with deviations in either direction graded as +2, +1, or -1, -2, etc., for laryngeal exposures that are too aggressive or too limited, respectively. Of course, precise definitions and clinical validation for a new classification system would be essential.

Conflicts of interest None declared.

Editorial responsibility This submission was handled by Dr. Hilary P. Grocott, Editor-in-Chief, *Canadian Journal of Anesthesia*.

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