Correspondence

Awareness during anesthesia

To the Editor:
All anesthesiologists will join me in extending sincere sympathy to Ms. Hoogewerf, who was aware during surgery for an ovarian cyst (Can J Anaesth 1998; 45: 821). This mishap is one of the twenty sudden occurrences which anesthesiologists most dread while they administer anesthesia. Though very rare, some physicians become so fearful of encountering such an event that they withdraw from the practice of anesthesia.

However, Ms. Hoogewerf makes the very important point that the administration of anesthesia is very difficult, and fraught with uncertainty, because we are not dealing with predictable programmable inanimate objects, but are anesthetizing people, whose condition may change with startling rapidity.

This morning I anesthetized two consecutive patients: the first required only 20% of the expected quantity of anesthetic agent and recovered within 20 mins while the family asked three times why recovery was so slow. The second patient required 100% more anesthesia than the average patient, but was adequately anesthetized and recovered normally.

We should all be grateful to your correspondent for highlighting the problems of providing anesthesia, and resolve to be aware of the difficulties and the possibility of awareness during light anesthesia.

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Concept of endotracheal intubation

To the Editor:
I read with interest the letter from Orlando R. Hung regarding the concept of endotracheal intubation.[1] The endotracheal tube (ETT) is generally placed under direct vision. When visual access to the vocal cords is not possible, a non-visual technique is then employed. However, a *non-visual* technique is not a *blind* technique.[2] They are *guided* techniques; efforts are always made to guide the ETT into the larynx. The guidance can be patient's breathing (either the sound or the expiratory CO_2),[3,4] or the feeling of the finger (digital intubation) within the mouth or over the neck. It also can be an introducer inserted by various means including the use of a gum elastic bougie, lighted stylet, fibreoptic scope, or retrograde wire.[5] Employment of specially designed equipment such as a laryngeal mask airway (LMA or LMA-FASTRACH), or an oral airway intubator (Augustine guide) are other alternatives. Therefore, it would be appropriate to classify endotracheal intubation techniques into two major groups: 1. visual intubation and 2. non-visual intubation or guided intubation. Fibreoptic intubation is a type of *introducer intubation* which is a subgroup of guided intubation.[5]

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REFERENCES
1 *Hung OR.* Misconception of tracheal intubation using a fibreoptic bronchoscope (Letter). Can J Anaesth 1998; 45: 496.
2 *King HK, Huntington C, Khan AK.* Blind nasal intubation is not performed blindly (Letter). Anaesth Intensive Care 1995; 23: 260.
3 *King HK, Wooten DL.* Blind nasal intubation by monitoring end-tidal C02 (Letter). Anesth Analg 1989; 69: 412–3.
4 *King HK.* Awake oral breath-guided intubation (Letter). Anaesth Intensive Care 1997; 25: 316–7.
5 *King HK, Wang LF, Wooten DJ.* Endotracheal intubation using translaryngeal guided intubation vs percutaneous retrograde guidewire insertion (Letter). Crit Care Med 1987; 15: 183.

REPLY:

I must thank Dr. King for his interest in my comments. The prime objective of most Classifcations in medicine is to provide a prediction of an outcome. e.g. Mallampatti classification has been used to predict difficult laryngoscopic intubation, and the American Society of Anesthesiologists classification has been used to correlate with peri-operative mortality and morbidity.[1-2] Although the classification of intubating techniques does not have a predictive value, it may serve as a useful tool to illustrate conceptually different intubating techniques for teaching purposes. While I welcome Dr. King's