

aperture bars on the LMA-Unique™ compared to the LMA-Classic™. While recognizing that the gap is indeed narrower on the LMA-Unique™, this is not the location where the Aintree intubation catheter (Cook Incorporated, Bloomington, IN, USA) becomes caught. In fact, the bars are relatively elastic and will easily give way under pressure. A 6.0 mm internal diameter endotracheal tube (Portex Profile™, Smiths Medical, London, UK) can easily pass through both a size 4 LMA-Classic™ and LMA-Unique™.

Both the LMA-Classic™ and the LMA-Unique™ have a marked sharp ridge posteriorly at the opening of the LMA™. When the LMA™ is *in situ*, the curvature of the tube forces the Aintree catheter posteriorly and into this ridge. Although this ridge is somewhat larger on the LMA-Unique™, the Aintree catheter often catches at this point on the LMA-Classic™ as well. Using a fibroscope significantly smaller than the 4.7 mm internal diameter of the Aintree catheter will result in a large gap between the fibroscope and the Aintree catheter, making the tip of the Aintree catheter more likely to catch on this ridge. I have found this to be less of a problem with both types of LMAs when using a larger 4.1 mm fibroscope *in lieu* of a 3.4 mm fibroscope.

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Videolaryngoscopy for tracheal intubation: the guide channel or steering techniques for endotracheal tube placement?

To the Editor:

The difficult airway remains a challenge even for the most experienced anesthesiologist. Recently, promising video- and optical-laryngoscopes have been developed to assist intubation for patients in whom direct laryngoscopy would be difficult.^{1,2} Although a number of differences exist between these devices, they can broadly be classified into two categories: those equipped with a guiding channel that directs the endo-

tracheal tube (ETT) through the glottis, and those for which the ETT must be steered by the operator. Examples of the first category include the Airtraq® (Prodol Meditec, Vizcaya, Spain) and the Airway Scope® (AWS; Pentax, Tokyo, Japan). Examples of the second category include the Glidescope® (Verathon Inc, Bothell, WA, USA) and the McGrath® (Aircraft Medical, Edinburgh, UK) videolaryngoscopes.

Previous reports have shown that obtaining a full view of the glottis with devices of the second category does not always guarantee a successful intubation because steering the ETT may be difficult.³ Potentially, devices of the first category (with a guiding channel) may facilitate ETT insertion once the glottis has been aligned with the centre of the laryngeal inlet on the liquid crystal display. Our recent experience involving a patient with a difficult airway challenges this theoretical advantage.

General anesthesia was planned for a 48-yr-old female patient undergoing laparoscopic cholecystectomy. Her body mass index was 21.2 kg·m⁻². Examination revealed a Mallampati class II upper airway, an interincisor gap of 41 mm and a thyromental distance of 47 mm. After induction of general anesthesia, adequacy of bag-mask ventilation was verified before administering the muscle relaxant. Direct laryngoscopy with a MacIntosh metal blade revealed a Cormack-Lehane grade III view (no intubation attempt was made). An Airtraq® was subsequently used and a full view of the glottis was obtained very easily. However, despite several optimization maneuvers (withdrawal and vertical pull-up) the glottis remained in the upper panel of the image, and its alignment with the centre of the view was impossible. Advancing the ETT through the guiding channel consistently directed it posteriorly towards the esophagus. Two anesthesiologists, experienced with the technique, encountered the same problem on three different attempts. Finally, we chose to use the McGrath® laryngoscope.⁴ Once again a full view of the glottis was easily obtained. This time, a 7-mm ETT mounted on a pre-formed malleable stylet (hockey-stick shape) was then easily maneuvered and advanced into the trachea on the first attempt.

As previously reported with other devices, obtaining a full view of the glottis with the Airtraq® does not guarantee a successful intubation.³ This case illustrates that in a patient with a very anterior larynx, aligning the glottis into the centre of the Airtraq view may not be feasible. In such a situation, directing the ETT between the vocal cords may prove to be impossible since the guiding channel directs the tube posteriorly. We could have threaded a fiberoptic scope or an Eschmann bougie through the ETT mounted

on the Airtraq® channel to help guide the tube. Both techniques have been used successfully to overcome similar difficulties encountered with other videolaryngoscopes.^{5,6} Instead, we used the McGrath videolaryngoscope combined with an appropriately-shaped stylet. This provided greater maneuverability to steer the ETT into correct position, resulting in swift and easy tracheal intubation. This experience illustrates a limitation of videolaryngoscopic techniques and how different devices may be used in a complementary manner.

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