

In reply: Lingual traction to aid fiberoptic intubation

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To the Editor:

We thank Dr. Liu et al. [1] for the comments. Our main objective was to evaluate the effects of lingual traction on fiberoptic intubation (FOI) in patients with difficult airways [2]. Accordingly, predictors of difficult airways were not evaluated, but were referred to when determining subject eligibility. We used a 6.0-mm outer-diameter fiberoptic bronchoscope, and endotracheal tubes (ETT) with internal diameters of 7.0 mm in females and 8.0 mm in males. While we agree that positioning the ETT bevel posteriorly can improve the success of FOI, this difference is negligible in our experience. We also agree that not controlling for external laryngeal manipulation, jaw thrust, and head/neck position was a significant limitation of our study that created a performance bias as acknowledged in our manuscript. Future studies should control for these factors.

The authors refer to the study by Durga et al. that failed to produce full airway clearance with lingual traction and FOI in a significant number of patients [3]. However, this

study excluded any patients with known or suspected difficult intubation.

As Liu et al. discuss, our results suggest that using lingual traction with the Williams airway can provide a higher first attempt FOI success rate than with the Williams airway alone. However, the benefit of lingual traction for FOI in patients with difficult airways is evident from our study. We agree and recommend using the Williams airway in these situations.

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