



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

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Received: 9 May 2016/Revised: 10 May 2016/Accepted: 9 June 2016/Published online: 21 June 2016  
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## To the Editor,

We congratulate Dr. Gu *et al.* for their sound, thought-provoking article that addresses the issue of optimizing intubation conditions during video laryngoscopy by purposely using a restricted laryngeal view.<sup>1</sup>

Teaching direct laryngoscopy generally focuses on obtaining the best possible glottic view, with the ease of intubation generally being *directly* proportional to this view. Unlike direct laryngoscopy, however, the authors have shown that a deliberately restricted view of the glottis when using GlideScope© GVL video laryngoscopy is associated with both improved ease and decreased time to endotracheal intubation - in essence, the ease of intubation was *inversely* proportional to the quality of the glottic view.

The authors' findings may have a significant impact on the interpretation and conclusions of video laryngoscopy research that uses the glottic view [e.g., modified Cormack-Lehane<sup>2</sup> or POGO (percentage of glottic opening) score],<sup>3</sup> as a surrogate end point for ease of intubation.<sup>4</sup> This assumption may simply not be the case. The authors' findings may also have a significant impact on optimizing teaching of video laryngoscopy skills. Perhaps we should curb our enthusiasm about obtaining the best view of the

glottis and, instead, emphasize that this approach is a complete departure from what is currently being taught regarding direct laryngoscopy. It raises the question as whether, given their findings, we should reject the view of the glottis as a surrogate end point for intubation in articles about video laryngoscopy.

It is exciting to see video laryngoscopy research maturing beyond simply the *direct laryngoscopy vs video laryngoscopy* paradigm into how best to optimize endotracheal intubation when we have access to both techniques. Just as video laryngoscopy and direct laryngoscopy are different but complementary techniques, it is not surprising that their optimal research and teaching approaches may differ as well.

**Conflicts of interest** None declared.

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

## References

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This letter is accompanied by a reply. Please see *Can J Anesth* 2016; 63: this issue.

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