



Using a Mcintosh blade for retromolar intubation: a comment

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Received: 5 July 2017 / Accepted: 7 August 2017 / Published online: 16 August 2017
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To the Editor,

We read with great interest the airway management of a one-month-old infant who presented with an obstructive sublingual cyst, as reported by Kabukcu *et al.* in the *Journal*.¹ The authors successfully intubated the patient using a size 0 Mcintosh blade with a right retromolar approach. Although the retromolar approach with a Miller blade has been reported for macroglossia,² we stress, based on our experience, that other, probably less hazardous, methods could be used in such complex situations.

- The size of the cyst could have been reduced by needle aspiration based on magnetic resonance imaging (MRI) findings, as has been done during the neonatal period. This approach would have made direct laryngoscopy easier while reducing the risk of cyst rupture during laryngoscopy.³
- Nasal flexible bronchoscopic intubation could have been performed because MRI showed that the pathway to the glottis and trachea was unobstructed. This approach could have been accomplished under intravenous sedation (e.g., dexmedetomidine) or inhaled general anesthesia administered via a

nasopharyngeal airway.⁴ Moreover, nasotracheal intubation could have improved the surgical approach.

- Muscle relaxation in case of difficult intubation caused by oropharyngeal obstruction has the advantage of eliminating the risk of laryngospasm. It does, however, carry a risk of increased obstruction caused by loss of muscle tone even if it is often possible to ventilate via a nasopharyngeal airway.⁵ We therefore favour maintaining spontaneous ventilation to ensure oxygenation.

The main indications for using the retromolar (or paraglossal) approach is a discrepancy between tongue size and submandibular space (e.g., micrognathia). Introducing the laryngoscope blade laterally, to the side of the tongue, reduces the distance from the teeth to the larynx while bypassing the tongue. The use of a straight blade is easier because its section is narrower than that of a curved blade, and the endotracheal tube can be inserted into it up to the laryngeal inlet. In the presence of macroglossia, however, the C-shaped section of a Miller blade is often unable to keep lingual tissue away, in which case a straight blade with a Z-shaped section (e.g., Seward or Cardiff blade) should be used.

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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This letter is accompanied by a reply. Please see *Can J Anesth* 2017; 64: this issue.

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