quate during clinical applications. The obvious advantage of this configuration is that set-up is virtually instantaneous in urgent situations.

I hope that the suggestions offered are found to be useful by those readers now gaining experience with the Bullard laryngoscope.

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REFERENCE

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A modified Williams airway intubator to assist fiberoptic intubation

To the Editor:

The Williams airway intubator¹ is found by many authors to be the preferred conduit to facilitate fiberoptic tracheal intubation.^{2,3} Because it was originally designed to assist blind orotracheal intubation, it offers easy access for the fiberoptic scope to pass through the glottis into the trachea while the endotracheal tube can be threaded through its circular lumen. However, to remove the Intubator after successful intubation is cumbersome: it can be extracted only through the proximal end of the endotracheal tube with the connector detached. To overcome this difficulty, I have modified the intubator by cutting a 7 mm wide slot in its anterior wall (see Figure below). With this slot, the fiberoptic scope can be eased out of the intubator once it is in position before the

endotracheal tube is advanced into the trachea. Before settling on this modification, I have also considered the option of a side slot. During awake fiberoptic intubation, the intubator also functions as a bite block and structural integrity in the anteroposterior dimension is important. A side slot will compromise this integrity.

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- 2 Palazzo MGA, Soltice NJ. A new aid to fiberoptic bronchoscopy (Letter). *Anaesth Intensive Care* 1983; 11: 388-9.
- 3 Rogers SN, Benumof JL. New and easy techniques for fiberoptic endoscopy-aided tracheal intubation. *Anesthesiology* 1983; 59: 569-72.

LMA-FasTrach™

To the Editor:

A 51-yr-old, 120-kg, female patient was scheduled for a three-hour percutaneous nephrolithotomy in the prone position. The patient was known to have a difficult airway but had not been intubated for 25 yr. Three days before scheduled surgery, a senior colleague attempted laryngoscopy four times and decided the patient was an impossible intubation. A fiberoptic awake technique was strongly recommended for any further airway management. On the day of scheduled surgery, it was decided to attempt intubation using the new LMA-FasTrach™.

Preoperative sedation of 5 mg diazepam *po* was given. Induction of anesthesia was accomplished using 2 mg midazolam, 0.625 mg droperidol, 250 µg fentanyl and 200 mg propofol. The patient was allowed to breathe sevoflurane until all reflexes were obtunded and deep anaesthesia obtained. At that point the LMA-FasTrach #4 airway was introduced without difficulty. The patient was allowed to breathe spontaneously through the mask while deep anaesthesia was maintained. At this point, a well lubricated straight silicone reinforced 8 mm cuffed endotracheal tube was passed without difficulty through the FasTrach into the patient's trachea. Successful intubation was confirmed with endtidal CO₂. Throughout the procedure O₂ saturation remained between 98-100%. Once the airway was secured, the FasTrach was removed and the endotracheal tube was left *in situ*.

FIGURE