Fibreoptic and stylet aided orotracheal intubation: a different approach for the difficult intubation

To the Editor:

We report a technique of orotracheal intubation using the combination of a flexible fibreoptic bronchoscope (FOB) and a stylet in a patient whose operation was postponed initially because of failed intubation.

A 44-yr-old male was scheduled for total resection of the thyroid gland. After induction of anesthesia, a laryngeal view was not obtained by direct laryngoscopy. An experienced anesthesiologist made several attempts to intubate the trachea blindly, but failed also, so the patient was awakened for further evaluation. At a later date, conventional fibreoptic aided intubation was attempted but it was not possible to advance the FOB because of the direct contact of the tip with the laryngeal mucosa. Furthermore, the fibreoptic view was clouded by the presence of secretions. We then decided to combine the FOB and stylet within the endotracheal tube (ETT) for orotracheal intubation. Before the intervention, a stylet and adult size

FOB were lubricated with water-based jelly to facilitate movement within the ETT (internal diameter: 9 mm). The FOB was inserted into the ETT, 1–2 mm from the end of the ETT, followed by a stylet advanced to the end of the tube. After adjusting the image quality of the FOB, the tip of the ETT was bent 80–85° with the aid of the stylet (Figure). The operator then advanced the tube into the oropharynx while an assistant elevated the tongue with a laryngoscope. Advancement of the ETT from the oropharynx to the carina was performed under the direct vision of the FOB. The stylet was withdrawn as soon as the tip of the ETT passed the vocal cords.

In this technique, the FOB view may be limited by the tip of the ETT. On the other hand, manual movement of the ETT will provide clear visualization of the surrounding tissues and the glottis. The advantage of this technique is to convert a flexible FOB to a rigid scope simply by using a stylet. Also, it is possible to perform this technique with a pediatric FOB for ETT with a diameter of 6 to 8 mm.

Flexible fibreoptic intubation is a valuable technique and, generally, is chosen first in the management of difficult airways. However, when difficulty is encountered during intubation with a FOB in the anesthetized and paralyzed patient, combination of a stylet and bronchoscope within the ETT may prove useful.

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FIGURE Fibreoptic bronchoscope and stylet assembled within the endotracheal tube.

The Bullard laryngoscope and uvular edema

To the Editor:

We would like to report a case of uvular edema complicating endotracheal intubation with the Bullard laryngoscope. A 56-yr-old male presented for a sigmoid colectomy for carcinoma of the colon. There was no recent history of an upper respiratory tract infection and he was a non-smoker. His past surgical history included bilateral laparoscopic inguinal hernia procedures. The trachea was successfully intubated for this surgery using a Macintosh blade. Only the tip of the epiglottis was visible. The airway examination revealed a Mallampati 2 score, normal mouth opening, mentohyoid distance greater than 5 cm and good jaw mobility. He underwent general endotracheal