The Halifax group deserves great credit for designing and popularizing this instrument.

I believe the lighted stylet is the method of choice for elective intubations and is often the best solution for various types of difficult intubations. As a result of 12 years experience with lighted stylets,² I would suggest to your readers that they try an alternative technique for intubation with the Trachlight™.

I teach my students to use the same 'sniffing' position as they would with a laryngoscope. The tube is introduced from the right corner of the mouth with the tongue out of the way to the left. There is no need to put a hand into the patient's mouth. When learning the technique and for difficult cases a darkened room can be very helpful.

We use about a 75° bend at the tip of the tube. The handle of the Trachlight™ is held like a dart or a cigar. If the tube doesn't fall into place, one of three gentle manoeuvres may be required. If the light is in a pyriform fossa, the handle is rolled between thumb and fingers which sweeps the light sideways in front of the larynx until it shines brightly through the cords. If the light is in the esophagus, the tube is withdrawn slowly while keeping the tip pushed forward. It will then pop through the cords. Occasionally, a gentle forward thrust by an assistant on the angles of the jaw will be helpful.

Advancing the tube and withdrawing the stylet in one motion saves time. This is analogous to advancing an *iv* cannula and withdrawing the needle in one motion.

I encourage everyone to try both methods. Some will prefer the Halifax method and others the Vancouver method.

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REPLY:

We thank Dr. Graham for his interest in our paper entitled "Lightwand intubation using the Trachlight: a brief review of current knowledge".¹ We are delighted in acknowledging Dr. Graham's clinical experience regarding an alternative technique for intubation with the Trachlight™ (TL). During the last few years, many studies have confirmed the usefulness of the TL as a semi-

blind and easy to use technique for tracheal intubation in case of difficult laryngoscopy.^{2–4}

Notwithstanding Dr. Graham's suggestions, we investigated a combined technique (direct laryngoscopy and TL) for patients in whom a Cormack grade 3 laryngoscopic view was simulated. We will submit the results of our study for publication in the near future. We noticed that the probability of successful tracheal intubation using the combined technique (direct laryngoscopy and TL) is higher than when direct laryngoscopy or TL are used separately.

A multicentre study to evaluate the efficacy of the Trachlight™ in difficult tracheal intubations is warranted.

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Ropivacaine is not the S-isomer of bupivacaine

To the editor:

In their recent paper, Lim *et al.* incorrectly referred to ropivacaine as the S-isomer of bupivacaine.¹

Ropivacaine and bupivacaine are amino-amide local anesthetics belonging to the pipecoloxylidide group.² A propyl or butyl group on the piperidine nitrogen atom distinguishes the two; ropivacaine being the former and bupivacaine the latter.²

These local anesthetics are chiral compounds.² Although ropivacaine is a S (-) isomer, levobupivacaine is the true S (-) isomer of racemic bupivacaine.³

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Exchange of orotracheal tubes in a patient with difficult airway and hiatus hernia

To the Editor:

A 23-yr-old man (height approximately 155 cm, weight 38 kg) with acute respiratory failure required exchange of endotracheal tubes. He had spastic cerebral palsy at two months of age, had had spastic quadriplegia, mental retardation, severe scoliosis and repeated regurgitation and pneumonia due to hiatus hernia. The head and neck were fixed in a flexed position and the interincisor distance was 3 cm. Previously, tracheal intubation using a laryngoscope had failed, but was accomplished after considerable difficulty using a fiberoptic bronchoscope. The patient was sedated and ventilation assisted mechanically. One month later, pneumonia and fever developed and fibrescopy showed that the tracheal tube was partially obstructed by a sticky sputum, containing *streptococci*, *neisseria* species and *pseudomonas aeruginosa*.

There were risks of failed intubation, failed ventilation and pulmonary aspiration during tube exchange. We used the following method to minimize the risk of complications. A size 4 laryngeal mask airway was placed without difficulty while the endotracheal tube was still in place. A fibroscope and a 6.0-mm ID endotracheal tube were passed through the laryngeal mask. After cricoid pressure had been applied to prevent regurgitation, the cuff of the endotracheal tube in place was deflated, and the fibroscope inserted into the trachea, alongside the old tube. The old tube was removed, the new tube was then advanced over the fibroscope into the trachea without difficulty. Time from removal of the endotracheal tube to reintubation was about five seconds, apnea less than ten seconds and SpO₂ remained 100%. I believe that the laryngeal mask is a useful adjunct for the exchange of endotracheal tubes.¹

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