We share the authors' concern regarding possible esophageal injuries, however, most reported esophageal injuries are associated with over-inflation of the distal balloon of the Combitube with 20 to 40 mL of air (instead of the recommended 10 mL volume with the Combitube 37 Fr, or 12 mL with the Combitube 41 Fr).² We believe that strict adherence to the manufacturer's guidelines regarding the inflation of Esophageal tracheal Combitube cuffs may prevent potentially life-threatening complications such as esophageal injuries.

Sonia J. Vaida MD
 Pennsylvania State University College of Medicine,
 Hershey, USA
 E-mail: svaida@psu.edu
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Reply:

We thank Dr. Saida for her interest in our manuscript, and share her concerns regarding the possible role of Combitube size in the genesis of reported complications. In planning our retrospective study, we chose to document Combitube size, but unfortunately, the data recording done by the emergency medical technicians was incomplete for this component of the database. This made it impossible to include Combitube size in the analyses, and for this reason, we chose not report incomplete results. This limitation, reflecting a limitation of the retrospective design was addressed in the discussion.

We emphasize that the EMT protocol for selection of Combitube size was recommended by the manufacturer (small Combitubes for patients < 180 cm in height; large Combitube for patients > 180 cm in height). We cannot document that this protocol received strict adherence.

We agree with Dr. Saida that the use of an oversized Combitube may represent a risk factor for esophageal injury, although no supporting evidence exists in the literature. We also agree that the manufacturer's recommendations regarding balloon inflation should be strictly followed. Finally, we wish to emphasize that, given the incidence of complications found in our study, use of the Combitube should be limited to cardiopulmonary resuscitation situations where qualified personnel are unavailable for tracheal intubation.

Claude A. Trépanier MD
 Pierre C. Nicole MD
 Martin R. Lessard MD
 Hôpital de l'Enfant-Jésus du CHA, Québec, Canada
 E-mail: delalaitue@videotron.ca

A combined rigid videolaryngoscopy-flexible fibrescopy intubation technique under general anesthesia

To the Editor:

One of the difficulties associated with fibreoptic intubation is to maintain the fibrescope in the median plane while advancing its tip into the pharynx and towards the laryngeal inlet. Rigid videolaryngoscopy has recently been described in difficult airway management. Although videolaryngoscopy reveals the larynx more frequently than conventional direct laryngoscopy, it often proves difficult to advance the endotracheal tube towards the larynx¹ and through the cords. Use of a stylet helps greatly, however this blind stylet technique has a failure rate and risks airway trauma. Repeated attempts may increase risks of hypoxemia, cardiovascular stress and aspiration. As an alternative to this technique, we suggest the combined use of flexible fibrescopy with rigid videolaryngoscopy to utilize the strengths of both techniques.

The rigid videolaryngoscope (DCI, Karl Storz, Tuttlingen, Germany) is a laryngoscope whose Macintosh blade has fibreoptic bundles for illumination and transmission of the image onto an LCD screen. In our setting, the video screens for the fibrescope and videolaryngoscope are placed side by side. After induction of general anesthesia the anesthesiologist performing laryngoscopy introduces the videolaryngoscope until clear visualization of the upper larynx is obtained on the screen. Then, while holding the videolaryngoscope in place, the operator uses her/his right hand to guide the tip of the fibrescope as closely as possible to the glottic inlet. The second operator, the fibrescopist, completes passage of the fibrescope