Use of the nasotracheal Airtraq® to assist difficult nasal fiberoptic intubation

To the Editor:

The Airtraq® (Prodol Meditec S.A., Vizcaya, Spain) is an indirect laryngoscope that allows visualization of the vocal cords and facilitates intubation in patients with cervical spine immobilization.^{1,2} Further development has led to the design of a nasotracheal Airtraq®, allowing intubation through the nose under visual control. We report using the nasotracheal Airtraq®, in conjunction with a nasal fiberoptic bronchoscopy, to achieve a successful intubation rendered difficult by a rigid cervical collar and copious bloody secretions.

The patient, a 40-yr-old 85-kg man, was wearing a custom-made moulded thoracocervical rigid collar due to an unstable C2 fracture. He was scheduled for an elective reduction and osteosynthesis of a fractured mandibular condyle under general anesthesia. His preoperative airway assessment included a Mallampati grade IV with a mouth opening of 15 mm between his central incisors due to the mandibular fracture and cervical collar. Besides his recent trauma, his medical history was unremarkable.

Following preoxygenation and intravenous induction of general anesthesia (propofol 2 mg·kg⁻¹, fentanyl 2 µg·kg⁻¹, and vecuronium 0.1 mg·kg⁻¹), facemask ventilation was uneventful. Nasotracheal fiberoptic intubation with a 6.5-mm nasotracheal tube was attempted and unsuccessful due to copious bloody secretions and a collapsed orotracheal pathway. Also, maneuvers, such as pulling out of the tongue or jaw-thrust, were impossible due to the collar. After three attempts, desaturation occurred requiring further facemask ventilation, while general anesthesia was maintained by an infusion of propofol (5 mg·kg⁻¹·hr⁻¹). After restoration of oxygen saturation to 99% and a subsequent failed fiberoptic intubation, a nasotracheal Airtraq® was introduced through the patient's mouth while fiberoptic was still in progress. At this point, the epiglottis and vocal cords were easily visualized. The nasotracheal Airtraq® operator gave verbal directions (up, down, left, right, forward, and back) for the fiberoptic, and tracheal intubation was achieved. Correct positioning of endotracheal tube placement was confirmed by capnography. The surgical procedure was uneventful, and at the end of the operation, the patient's trachea was extubated without problems while he was awake. His recovery was uneventful.

The successful completion of this case, in the face of

bleeding from nasal mucosa and a limited mouth opening due to the presence of a cervical collar, illustrates a potential role for the nasotracheal Airtraq® device in a difficult nasotracheal intubation under general anesthesia. However, caution must be exercised when using the nasotracheal Airtraq® in this type of case, as the instrument has been reported to cause bleeding and oropharyngeal lesions.^{3,4} A cautious airway assessment and definition of rescue plans must always be available in the management of patients with restricted neck mobility and limited mouth opening.

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Editorial elective

To the Editor:

I write to express my gratitude for the opportunity to undertake a one-month editorial elective with the *Journal*, which I recently completed. I am the second anesthesia resident to have participated in this *Journal*-related pilot project. Owing to this experience, I have gained a new appreciation for the world of scientific and medical writing and biomedical publishing, an area that few residents understand or appreciate.

Ideally, a formal editorial elective should be available to any anesthesia resident interested in research and/or scholarly publication.

This month-long elective was like “the ultimate journal club”, as recently described by a *New England Journal of Medicine* editorial fellow.¹ For my part, I was given new research to review on a daily basis which helped me to improve my skills of critical appraisal. In all, I had the opportunity to engage in the editorial peer review process from beginning to end. I participated in the day-to-day editorial office activities, including screening papers as they are first submitted, participating in decisions to determine the manuscripts that should advance to editorial peer review, discussing editorial decisions after reviewers had completed their assessments, and learning the art of written communication. My responsibilities gradually increased under the guidance of the Editor-in-Chief, and, during that time, I was provided with many resources on scientific and medical writing and journal editing. I participated in numerous discussions about the many factors that determine decisions regarding the manuscripts submitted to the *Journal*. In addition, in order to gain an understanding of the editorial process from an author’s point of view, I undertook writing two book reviews.

Few medical trainees consider science editing as a career option. A recent article in *Science Editor* explores the possibilities available and provides some valuable resources and suggestions on securing a science-editing position.² It is a field that involves many skill sets, including communication, organization, computer skills, time management, leadership, and, of course, a good knowledge of English grammar.³ An editorial elective gives medical residents and fellows first-hand experience on what it is like to sit in the chair of the Editor-in-Chief, and it exposes them to the possibility of a role in some aspect of an academic career path, such as guest editor or editorial board member.

Editorial internships offered by major medical journals are typically one year in duration.¹ However, since 1998, The Radiological Society of North America has been successful at offering a month long editorial fellowship.⁴ The fellows’ experiences and the many advantages of completing an editorial fellowship are outlined on the Society’s website (http://www.rsna.org/Publications/editorial_fellows.cfm). However, this fellowship is geared towards the physician who has experience working as a reviewer for a major scientific journal. In my opinion, it is important to make editorial opportunities available for interested senior trainees who may have minimal experience in the field of science editing. If a sound appreciation of scientific writ-

ing and communication can be developed at an early stage, this propensity will likely continue throughout one’s professional career. The *Journal of Obstetrics and Gynaecology* offers a successful month-long internship that accepts applicants who are in residency or fellowship training, or who have recently completed their training.⁵ Their Editorial Board accepts two or three of the best applicants per year. This could be a model to follow if the *Journal* were to implement a formal editorial elective.

I would be delighted to see the *Journal* move forward from the positive experiences of this pilot project to offering a formal editorial fellowship to senior residents and fellows. This experience falls within the CanMEDS roles. Although an editorial elective may increase the workload of the Editor-in-Chief, the endeavour could be a worthwhile investment, as, hopefully, these students will contribute to future scientific journals, perhaps by submitting well-written manuscripts, by becoming a peer reviewer, or even by considering a future role as Editor-in-Chief.⁵

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Editor’s note:

We are delighted to receive such enthusiastic feedback, as observed from Dr. Rodgers’ letter and from formal evaluations relating to recent experiences of senior residents in anesthesia who have undertaken editorial elective opportunities with the *Journal*. As Dr. Rodgers points out in her letter, we recently began offering one-month electives as a pilot project to senior residents in anesthesia who had expressed an interest in learning about the basic elements of editorial peer review and scientific and medical publishing. The elec-

tives involve participation in the day-to-day editorial activities of the *Journal* and taking part in selected projects. In the months ahead, we hope to make such opportunities available to interested residents who are enrolled in any anesthesia program in Canada and who have some prior experience in either basic science or clinical research.

Donald R. Miller MD, Editor-in-Chief

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