

can be attached directly to the 15 mm connector of an endotracheal tube or an ETC. With a suction booster in place, the #2 lumen of the ETC becomes, in effect, an instantly available, perfectly positioned, high capacity suction catheter. Should regurgitation occur upon release of cricoid pressure, the intubator can immediately clear the pharynx merely by placing the index finger over the suction-control opening of the suction booster. Once the pharynx is emptied, the index finger is lifted, releasing the suction, the ETC is passed into the esophagus, and the cuff and pharyngeal balloon are inflated.

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REFERENCES

- 1 Crosby ET, Cooper RM, Douglas MJ, et al. The unanticipated difficult airway with recommendations for management. *Can J Anaesth* 1998; 45: 757-76.
- 2 Ruben H, Hansen E, MacNaughton FI. High capacity suction technique. A method of reducing the aspiration hazard during induction. *Anaesthesia* 1979; 34: 349-51.

The difficult airway and BURP - a truly Canadian perspective

To the Editor:

I read with interest and admiration the recent Special Article on "The unanticipated difficult airway with recommendations for management",¹ and the accompanied editorial.² The authors of the article should be congratulated for a thorough review of the subject and I agree with the editorial that the recommendations are concise, easy to follow, and in some ways, superior to the ASA algorithm. Having said that, I am somewhat puzzled at the omission of the distinctly Canadian contribution. I am referring to the fact that the "BURP manoeuvre" was introduced and the term coined by the late Dr. Richard Knill³ of London, Ontario whose power of observation was legendary. Yet, the original reference was not cited, and the reference quoted was that of Takahata *et al.*⁴ whose work was based on the report by Knill. Moreover, the discussion overlooked an important point, which was likewise missed by Takahata *et al.*, i.e. the BURP manoeuvre is far more likely to be successful when the laryngoscopist himself applies the pressure to determine the optimal direction and displacement of the larynx to obtain the best view. After determination of the optimal force and displacement,

the laryngoscopist can then direct his or her assistant to reproduce the condition. This allows the laryngoscopist to delineate the "best" exposure that can be achieved and not simply accept what the assistant can provide as "optimal". This was implied but not spelled out as such in Knill's original publication. This is an important point, one which I have applied on more than one occasion to spare a patient the almost certain fate of a "crash" cricothyrotomy.

On another issue, the algorithm did not outline for the readers the exact sequence leading to the decision box of "ventilation possible?" Many American anesthesiologists would routinely withhold muscle relaxants until they have ensured the ability to ventilate by mask. This, in my opinion, is a misguided approach, and should be reserved only for patients anticipated to be difficult to ventilate/intubate and not used on a routine basis. Since the algorithm is for the "unanticipated" difficult airway, I would assume "induction of general anesthesia" to include the administration of muscle relaxants. In the published paper, this is not entirely clear.

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- 2 Finucane B. The difficult airway - a Canadian perspective (Editorial). *Can J Anaesth* 1998; 45: 713-8.
- 3 Knill RL. Difficult laryngoscopy made easy with a "BURP". *Can J Anaesth* 1993; 40: 279-82.
- 4 Takahata O, Kubota M, Mamiya K, et al. The efficacy of the "BURP" maneuver during a difficult laryngoscopy. *Anesth Analg* 1997; 84: 419-21.

REPLY:

Dr. Southwick describes a technique which may be useful in reducing the likelihood or the severity of aspiration when releasing cricoid pressure during placement of a Combitube® in an at-risk patient.

Dr. Lam points out what might seem to be a surprising oversight for a group ostensibly offering a Canadian perspective on airway management. In his description of the "BURP -manoeuvre", Knill credited Wilson for his observation that anterior laryngeal pressure improved laryngoscopic view, reducing the incidence of Grade III and IV views from 9.2% to 1.6%.¹ Although Knill described both the rationale and method for application of BURP, it was Takahata who detailed the impact of the manoeuvre on the laryngoscopic view in 630 patients. Takahata noted a