

difficult airway scenarios involving co-operative adult patients who required tracheal intubation; physicians were asked to identify their preferred management technique. Experienced practitioners tended to use higher risk induction techniques. The use of adjuncts to the direct laryngoscope or alternative devices including the Bullard laryngoscope or the lighted stylet was uncommon. In the patient with a history of previous difficult intubation, 60% of experienced practitioners would induce general anesthesia and 59% would proceed with direct laryngoscopy. In half of the institutions surveyed, the lighted stylet, retrograde intubation kits, the Combitube, gum elastic bougies, or the Bullard laryngoscope were unavailable and 17% of anesthesiologists did not have access to the laryngeal mask airway.²

It is likely that the major reason for the lack of motivation within the specialty to learn, apply and teach newer techniques in airway management, is that airway disasters are sufficiently rare that one may function for a very long time under the illusion that it will never happen. Mannequins and simulators will likely have their greatest utility for training with techniques that may constitute a small but finite and different risk to patients (i.e. esophageal injury after Combitube insertion).

Edward Crosby MD
Ottawa, Ontario

REFERENCES

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REPLY:

We are pleased to receive endorsement of our deliberations on the unanticipated difficult airway from Benumof who is a keen and learned master of this important topic.

Benumof suggests further modification of the definition by adding a fourth category. However, he already stated that Crosby et al.'s definition "comes pretty close to objectively covering the clinical realities of difficulty for everyone". Whatever definition we agree upon, we must strive for universal agreement so that we can collect some meaningful data on this important topic world-wide. Benumof was surprised that Crosby et al. did not comment on the algorithm in the text of the article. I suggest that the Crosby et al. algorithm is a simplified version of the ASA algorithm.

As both the Crosby and ASA algorithms are comparable most clinicians would opt for a more concise version. One of the purposes of an algorithm is to encourage clear thinking. Complicated road maps are distracting and sometimes lead people astray.

Finally, Benumof is puzzled once again by my observation that Crosby et al.'s paper expresses a "distinctly Canadian viewpoint". I agree that the content in Crosby et al.'s article does not differ very much from the American viewpoint. It really boils down to a difference in style.

Brendan T. Finucane MBBCH FRCA FRCPC
Edmonton, Alberta

REFERENCE

- 1 Crosby ET, Cooper RM, Douglas MJ, et al. The unanticipated difficult airway with recommendations for management. *Can J Anaesth* 1998; 45: 757-76.

LMA/FOI and CAFG

To the Editor:

We disagree with the CAFG statement that fiberoptic intubation is "compromised in the anesthetized patient."¹ They cite but one review article in support, based on the author's "personal experience supplemented by a limited literature review".² This, despite the citation methodology that claimed: "only titles including original data were included; excluded were ... titles with no original data (reviews, editorials, comments)".¹ The CAFG has ignored the considerable evidence-based literature on fiberoptic intubation of anesthetized patients.

We have demonstrated that junior residents, using anesthetized patients, learn fiberoptic as readily as laryngoscopic intubation, without increasing morbidity or surgical delay.³ Others have reported similar results.⁴⁻⁸ Although we do not advocate this technique for patients with recognized difficult airways or airway pathology, we have found expertise gained during elective fiberoptic intubation of anesthetized patients translates into equal facility in fiberoptic intubation in unrecognized difficult laryngoscopy in anesthetized patients, and also in awake fiberoptic intubation, (as did Marsch.⁹)

Interestingly, the CAFG displays an open attitude to newer devices - the lighted stylette and intubating laryngeal mask airway. Could the authors been seduced by new, and therefore glamorous, equipment? New devices are appealing - all is yet to be explored, yet to be written. Career investigators might find such

devices more tempting to investigate and advocate than older, already well-explored instruments. Slavish acceptance of novelty can lead to unfortunate 'fads', later recognized to resemble the emperor who is, if not naked, at least ill-clad.

A.F. David Cole MD
Joseph S. Mallon MD FRCPC
Toronto, Ontario

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- 8 Benumof JL. Management of the difficult adult airway. With special emphasis on awake tracheal intubation. *Anesthesiology* 1991; 75: 1087-110.
- 9 Marsch SCU, Aeschbach A, Achaefer H-G. Teaching awake fiberoptic intubation in patients without specific medical indication. *Anesthesiology* 1995; 83: A1014.

REPLY:

The intent of our project was to review the literature since the ASA Guidelines and to determine if previous recommendations should be modified, and to offer guidance regarding newer airway devices.

Cole and Mallon¹ studied eight residents who, after 1000 tracheal intubations (quarter with the flexible fiberoptic endoscope [FFE]), were assessed during tracheal intubation in a further elective 131 patients, 59 with the direct laryngoscope, 72 with the FFE. In the case of FFE-facilitated tracheal intubations, a catheter was placed in the oropharynx before the procedure began for

continuous oxygen insufflation. It took nearly twice as long to complete fiberoptic intubation; only 73% were performed within one minute of apnea. Would this be reproducible in the unanticipated failed intubation, without dedicated assistance?

We acknowledged the value of the FFE in the management of the unanticipated difficult intubation. We suggested that its use was more difficult in the setting of a paralysed, apneic patient, particularly when the airway might be soiled by blood or secretions. Finucane also took exception to our reservations: "I tend to differ with them on this issue. Fiberoptic assisted intubation can be extremely useful even in anesthetized patients, but ... it requires practice, experience and an assistant to maintain the airway,"² (my italics) We cited evidence that tracheal intubation can be achieved rapidly and safely, without the need for an assistant, with the alternate devices reviewed.

With regard to newer devices, we did not mention the intubating LMA because, at the time, there was no evidence demonstrating its effectiveness. However, the other devices reviewed, with the exception of the McCoy laryngoscope blade, have been available for more than a decade.

Edward Crosby MD
Ottawa, Ontario

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- 1 Cole AFD, Mallon JS, Rolbin SH, Ananthanarayan C. Fiberoptic intubation using anesthetized, paralyzed, apneic patients. Results of a resident training program. *Anesthesiology* 1996; 84: 1101-6.
- 2 Finucane B. The difficult airway - a Canadian perspective (Editorial). *Can J Anaesth* 1998; 45: 713-8.

The Charlottetown Click

To the Editor:

We read with concern the letter by Dubois and colleagues describing insertion of the LMA using a semi-inflated rotational technique, the so called "Charlottetown Twist" (*Can J Anaesth* 1998;45:823). The authors make the unsupported statement that this technique is less traumatic than the standard recommended technique, but we consider this to be incorrect. There is no doubt that placement of the LMA with the mask aperture bars facing in the cephalad direction can occasionally be advantageous in moving the cuff from the mouth into the pharynx. The disadvantage is that the cuff must then be rotated back through 180° for the device to function. The authors state that this rota-