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.

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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 *Morris IR.* Fibreoptic intubation. Can J Anaesth 1994; 41: 996–1008.
3 *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.
4 *Schaeffer H-G, Marsch SCU.* Comparison of orthodox with fibreoptic orotracheal intubation under total i.v. anaesthesia. Br J Anaesth 1991; 66: 608–10.
5 *Smith JE, Mackenzie AA, Scott-Knight VCE.* Comparison of two methods of fibrescope-guided tracheal intubation. Br J Anaesth 1991; 66: 546–50.
6 *Finfer SR, Mackenzie SI, Saddler JM, Watkins TGL.* Cardiovascular responses to tracheal intubation: a comparison of direct laryngoscopy and fibreoptic intubation. Anaesth Intensive Care 1989; 17: 44–8.
7 *Roth AG, Wheeler M, Stevenson GW, Hall SC.* Comparison of a rigid laryngoscope with the ultrathin fibreoptic laryngoscope for tracheal intubation in infants. Can J Anaesth 1994; 41: 1069–73.
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 Mallon [1] studied eight residents who, after 1000 tracheal intubations (quarter with the flexible fibreoptic 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 fibreoptic 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. Fibreoptic 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.

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REFERENCES

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-