

- 2 Benumof JL, Feroe D. Swallowing topically administered 4% lidocaine results in nausea and vomiting. *Am J Anesth* 1998; 25: 150–2.

REPLY:

We would like to thank Dr. Benumof for his interest and suggestions. Our report described the occurrence of complete upper airway obstruction with progressive life threatening arterial oxygen desaturation during awake fiberoptic intubation in two cases.¹ Both patients had unstable cervical spine fractures and they were stabilized in halo traction. The objective of our report was to remind anesthesiologists that fiberoptic endoscopies under such challenging situations might lead to drastic complications as those which have been experienced by Dr. Benumof.

A combination of factors could have contributed to the occurrence of complete upper airway obstruction including, mainly, deep sedation and inadequate topicalization. However, we agree with Dr. Benumof that accumulation of perilaryngeal secretions might have played a role in the development of these complications. In our practice, we always ask the patient to gargle lidocaine sprayed or applied with pledgets and to suction all the fluids from the mouth with a Yankauer suction catheter. The Yankauer catheter is inserted a few times gently into the pharynx and is advanced gradually into the hypopharynx at the last stages of topicalization. The suction tip is also used to test the suppression of the gag reflex. We rarely use the suction port of the fiberoptic scope to suction perilaryngeal secretions. Nonetheless, Dr. Benumof's method of topicalization is an attractive technique and could ensure the clearing of most perilaryngeal secretions and fluid.²

Glenn McGuire MD
Hossam El-Beheiry MBBCh PhD FRCPC
Toronto, Ontario

References

- 1 McGuire G, El-Beheiry H. Complete upper airway obstruction during awake fiberoptic intubation in patients with unstable cervical spine fractures. *Can J Anesth* 1999; 46: 176–8.
- 2 Benumof JL, Feroe D. Swallowing topically administered 4% lidocaine results in nausea and vomiting. *Am J Anesth* 1998; 25: 150–2.

Bullard assisted trachlight technique

To the Editor:

I am writing to describe a method of intubation. For some time, we have been using a Bullard assisted trachlight (BAT) technique.

The intubating stylet is removed from the Bullard laryngoscope. It is used with the battery handle alone without the fiberoptic light source. The Bullard laryngoscope is inserted into the pharynx in the midline. When the vocal cords are visualized, the laryngoscope is moved to the left side of the mouth. Next, the trachlight is inserted into the right side of the mouth near the midline. The endotracheal tube is then guided under direct vision through the vocal cords. The endotracheal tube is fed distally into the trachea using a one handed trachlight technique.¹

When the Bullard laryngoscope is used with its stylet, perfect alignment is necessary to push the endotracheal tube through the vocal cords. The BAT method does not require a perfect view of the vocal cords. The trachlight allows for manipulation of the endotracheal tube independent of the view from the Bullard. Also, the trachlight better illuminates the vocal cords. The endotracheal tube position is therefore confirmed both by direct vision and the light transmitted in the anterior neck.

Personally I do not like probing blindly in the laryngeal area with the trachlight and feel limited in maneuverability when using the Bullard laryngoscope alone.

There is virtually no learning curve as this technique is rapidly learned by residents. Also, the Bullard laryngoscope is more easily and quickly cleaned than the fiberoptic scope.

Glenn McGuire MD
Martin Krestow
Toronto, Ontario

Reference

- 1 Crosby E. A tip for the trachlight. *Can J Anaesth* 1998; 45: 708–9.

Nasal intubation with the Trachlight

To the Editor:

Hung *et al.*^{1,2} describe a technique for nasal intubation with the Trachlight (TL) in which the stylet is removed to make it more pliable and flexible for atraumatic passage through the nose. We had poor success rate without the stylet due to difficulty in redirecting the light towards the glottis. We describe Trachlight-guided nasal intubation without removal of the stylet.

A 17-yr-old, 65-kg, ASA I man presented for repair of a fractured jaw: mouth opening was 21 mm. The nostril was topicalised and a cricothyroid puncture performed with lidocaine. An 8 mm flexible tracheal tube (TT) was mounted on a TL with the stylet in