
Correspondence

TRACHLIGHT™ - Learning tips

To the Editor:

After I had performed more than 100 Trachlight intubations, (five difficult - grade 3 view by direct laryngoscopy), I found that the following tips improve successful intubations with a light wand during the learning period:

1. Dimmed OR lights and one size smaller ETT (6 mm for female, 7 mm for male patients will be very helpful for a successful beginning.
2. Insert Light wand in the mouth with the right hand - start "on side" (right side of the mouth) and then rotate the wand medially towards the tip of the chin.
3. Use the left hand to elevate the jaw as much as possible.
4. Keep "rocking" the wand back and forth until the light glow is in the midline of the neck.
5. The stylet must be bent at the right length according to individual patient airway features (it is important to assess the patient's anatomy and to estimate the distance between the back of the pharynx and the cords - the "arm", the stylet's bent tip, should be bent at that length) - too short arm: ETT can not be advanced, in spite of the bright midline light - too long arm: difficult to find the midline, esophageal intubation very likely.
6. Correct angle - arm has to be bent at least 90°.
7. "Loss of resistance" and/or "click" can be felt when ETT is advanced under the epiglottis and through the cords.
8. Daily practice on "normal" airway is a prudent strategy during the learning period.

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References

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- 2 *Hung OR, Pytko S, Morris I, Murphy M, Stewart RD.* Lightwand intubation: II - Clinical trial of a new lightwand for tracheal intubation in patients with difficult airways. *Can J Anaesth* 1995; 42: 826-30.

Loss of resistance to saline - does the dripping bother you?

To the Editor:

The loss of resistance (LOR) technique is commonly used with either air or saline to identify the epidural space. LOR to air is simple and has been used for many years. Reported problems¹ include subarachnoid or intravascular injection of air resulting in headache or venous air embolism, and introduction of air bubbles into the epidural space possibly impairing spread of local anesthetics. Thus, some practitioners recommend LOR to saline as the preferred technique because it has not been associated with any of these complications.¹ However, one of the major disadvantages of this technique¹ is that it introduces fluid into the epidural space, which can be confused with a "wet tap". Tests have been described to determine the origin of the dripping liquid including warm temperature or glucose content as indicative of CSF. Recently, we reported a new test to determine epidural catheter placement using nerve stimulation^{2,3} which seems to have the ability to distinguish subarachnoid (bilateral motor response at low current less than 1mA) from epidural (motor response at higher current between 1 to 10mA) placement. In our practice, the new test allows for LOR to saline to be practiced more readily as a few drops aspirated out from the catheter need not be confusing. This test may allow greater peace of mind as it seems to identify the true position of the catheter and to rule out subarachnoid placement when a few drops of liquid drip back from the catheter after using LOR to saline.

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References

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- 2 *Tsui BCH, Gupta S, Finucane B.* Confirmation of epidural catheter placement using nerve stimulation. *Can J Anaesth* 1998; 45: 640-4.