

The method we describe will require further detailed evaluation; however it presents clear advantages for monitoring SjO_2 during CEA. Further refinements may improve this technique, including use of a guide wire for introducing the catheter into the internal jugular vein. In addition, this method should be compared with the conventional technique of monitoring SjO_2 during CEA in terms of 1) accuracy and continuity of measurements, 2) time necessary to obtain the measurement and 3) cost effectiveness evaluation. Further improvement and experience are essential for establishing the effectiveness and safety of this potentially promising approach to SjO_2 monitoring.

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Use of Shikani Flexible Seeing Stylet for intubation via the Intubating Laryngeal Mask Airway

To the Editor:

The Intubating Laryngeal Mask Airway (ILMA; The Laryngeal Mask Company, LMA North America, Inc., San Diego, CA, USA) has been designed to allow easier intubation than the LMA.¹ A fibroscope is useful in facilitating intubation via the ILMA, but when it is not

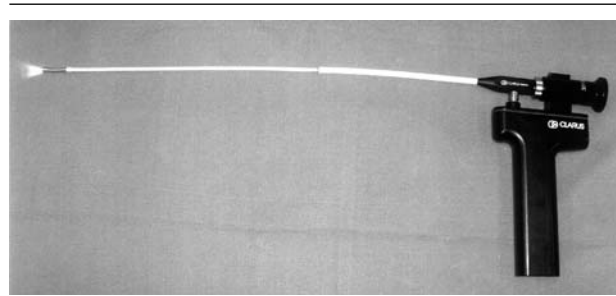


FIGURE The Shikani Flexible Seeing Stylet.

available, the "Shikani Flexible Seeing Stylet™" (Clarus Medical, Minneapolis, MN, USA; Figure) presents a useful alternative.^{2–4} We assessed the efficacy of the ILMA and Shikani Flexible Seeing Stylet™ associated technique using an ILMA endotracheal tube, or a standard endotracheal tube.

After obtaining written patient informed consent, the study was performed using the dedicated ILMA endotracheal tube on 13 patients (Group A), or a standard endotracheal tube into the ILMA in six patients (Group B). After positioning the ILMA, the operator introduced into the airway tube of the ILMA, the dedicated endotracheal tube or a standard endotracheal tube inside the Shikani's Stylet. While elevating the mandible, the endotracheal tube was advanced under direct vision through the vocal cords.

Twelve patients in Group A were successfully intubated: ten during the first attempt and two during the second attempt with an "up-down manoeuvre". In one woman the technique failed after two attempts and she was intubated successfully by direct laryngoscopy (Cormack-Lehane 1). In Group B the technique failed in four patients during the second attempt; they too, were intubated by direct laryngoscopy. In one patient, intubation was interrupted during the first attempt (blood in the airway tube) and intubation was achieved by direct laryngoscopy. One patient in this group, was successfully intubated during the second attempt, with "up-down manoeuvres".

The technique we describe does not seem to be useful with a standard endotracheal tube. This is unfortunate, as it may have been useful in an emergency situation. Jaw elevation was used for every patient, suggesting that experience with the ILMA is necessary. Our findings suggest that the ILMA is not indicated when the patient has a low posterior larynx (easy direct laryngoscopy, Cormack-Lehane 1), but

does confer benefits when the glottis is high and anterior (difficult direct laryngoscopy).¹

The major limitation of the Shikani Flexible Seeing Stylet™ is that it cannot be orientated in a precise direction, unlike the fibrescope, although it is cheaper, portable and malleable. The Seeing Stylet provides excellent illumination of the neck like a lightwand,⁵ permitting direct visualization too. In summary, the Shikani Flexible Seeing Stylet™ may facilitate intubation via the ILMA because it offers the advantages of the fibrescope technique with the characteristics of the lighted stylet. However, it does have technical limitations, and is more useful with an ILMA endotracheal tube compared to a standard endotracheal tube.

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Using a Glidescope for intubation with a double lumen endotracheal tube

To the Editor:

A 74-yr-old male (185 cm tall, 124 kg weight, body mass index 34 kg·m⁻²) was scheduled for left thoracotomy because of a left hilar mass. The patient's airway exam revealed a Mallampati class 3 airway, intercusor distance of 4.2 cm, neck flexion of 45°, neck extension less than 30°, and a hyomental distance of 3.0 cm.

A possible difficult airway was anticipated, and it was decided to use a Glidescope (Saturn Biomedical Systems, Burnaby, BC, Canada) for laryngoscopy. After preoxygenation, the patient was induced with fentanyl, propofol, and succinylcholine. The Glidescope was inserted and a Cormack-Lehane Grade I view of the vocal cords (VC) was seen. A 39 Fr left double lumen endotracheal tube (DLT) was inserted through the VC up to the bronchial cuff. Resistance was met and the DLT was unable to pass further. After mask ventilation, a second laryngoscopy with the Glidescope resulted in intubation of the DLT up to the tracheal cuff. The DLT position was checked with a fibreoptic bronchoscope which became wedged, and the DLT tube had to be removed. After mask ventilation, a third laryngoscopy with the Glidescope was performed, and a 37 Fr left DLT was successfully placed. Placement of the 37 Fr DLT in the left main bronchus was verified with the fibreoptic bronchoscope, and the operation proceeded uneventfully with good lung isolation.

Inserting endotracheal tubes for lung isolation can be difficult in patients with a difficult airway.¹ The Glidescope videolaryngoscope has been shown to be useful in patients with difficult airways.² Compared with the Bullard blade, another difficult airway device that has been used to insert DLTs,³ the Glidescope may also be easier to use² and does not need a special guide.⁴ Also, DLTs inserted with the Bullard blade may be successfully placed in the desired left main bronchus only 32% of the time.³

Several maneuvers helped in successfully placing the left DLT with the Glidescope. We suggest bending the stylet of the DLT so that the distal 16 to 20 cm of the DLT curve follows the curve of the Glidescope,⁵ and the other end of the DLT angles out to the right side. After the bronchial cuff passes through the VC, withdraw the stylet of the DLT about 2 cm. Then, rotate the DLT 90° counterclockwise while advancing the DLT to the desired depth.

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