

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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Optimum contents of a portable emergency airway equipment bag: results of an institutional survey

To the Editor:

Previous studies suggest that emergency crash carts may not always be readily available or adequately stocked.^{1,2} In view of this, anesthesia residents and fellows in our institution carry a portable airway equipment bag to all emergencies. We carried out a department wide survey in an attempt to optimize and standardize the equipment and drugs included in this bag.

Forty-two staff, fellows and residents in anesthesia working at the Hospital for Sick Children, Toronto, were surveyed in October 2004. A preliminary questionnaire was pretested by sending it to selected departmental members. Sixty-four possible items for inclusion in a portable airway equipment bag were listed on the final questionnaire, and sent to all departmental members. Each respondent was asked to provide a "yes" or "no" response to each item. Any item approved by more than 75% of the respondents was to be included in the bag. All items gaining 50 to 75% approval were discussed with the Trauma Committee of the department to determine if their inclusion was warranted.

The response rate was 50%. The Table lists the 37 items gaining more than 75% approval.

Three items, the laryngeal mask (LMA) size 1, gum elastic bougie and Ayre's T-piece received 50 to 75% approval, and were included in the list of equipment following discussion with the Trauma Committee. The LMA size 1 has been shown to be useful in neonatal emergencies³ and the gum elastic bougie is commonly included with the difficult airway equipment.⁴

The Ayre's T-piece anesthesia bag was a more popular choice than the self inflating bag as a device to provide positive pressure ventilation to the lungs.

TABLE Items gaining > 75% approval for inclusion in portable airway bag

<i>Items to be included</i>	<i>% Approval</i>
<i>Face mask</i>	
1	86%
2	95%
3	95%
4	90%
5	86%
<i>Guedel airway</i>	
3	81%
4	86%
5	95%
6	95%
7	100%
8	95%
9	81%
Straight blade size 1	95%
Curved blade size 3	90%
<i>Uncuffed endotracheal tubes</i>	
2.5	90%
3.0	90%
3.5	86%
4.0	86%
4.5	81%
5.0	76%
5.5	76%
<i>Cuffed endotracheal tubes</i>	
5.5	76%
6.0	90%
6.5	76%
7.0	86%
<i>Laryngeal mask</i>	
2	90%
3	95%
4	81%
Stylet	90%
Macgills forceps	76%
<i>Drugs</i>	
Propofol	76%
Suxamethonium	95%
Atropine	95%
Rocuronium	76%
Ketamine	76%

Perhaps the respondents had greater familiarity with the T-piece and were conscious of the ready availability of self inflating bags on all wards in at our institution.

We believe the reconstituted portable airway equipment bag we describe contains appropriate equipment to deal with immediate cardiopulmonary management problems in emergency situations.