

1) lidocaine spray or FOB stimulation to the cords will result in irreversible laryngospasm in these patients; 2) a 4-mm FOB is inadequate in this situation due to a narrow field of view, distorted anatomy, potential bleeding from a friable tumour, and a narrow or closed posterior pharyngeal space; 3) if you were lucky enough 'God willing' to insert the FOB into the larynx of this airway compromised patient, the sheer terror of now completely occluding the airway would result in an acutely distressed uncooperative patient. An extremely ugly and potentially deadly situation.

We also consider the use of the lighted stylet to be totally inappropriate to this scenario.

Also of concern is that the appropriateness of this practice was not challenged in either the discussion section of the article or in the accompanying editorial.³

We refer you to an extremely useful editorial that we commend to your readers.²

We suspect that the results of your Canadian survey reflect similar opinions in Australia, our "Difficult Airway Societies" will have to work harder to inform and teach best practice airway skills.

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References

- 1 *Jenkins K, Wong DT, Correa R.* Management choices for the difficult airway by anesthesiologists in Canada. *Can J Anesth* 2002; 49: 850–6.
- 2 *Mason RA, Fielder CP.* The obstructed airway in head and neck surgery. *Anaesthesia* 1999; 54: 625–8.
- 3 *Hung O.* Airway management: the good, the bad, and the ugly (Editorial). *Can J Anesth* 2002; 49: 767–71.

REPLY:

*A patient with laryngeal tumour presenting with stridor for laryngeal surgery is a daunting situation to deal with. The purpose of our survey was to obtain the anesthesiologist's first choice for airway management of the scenarios stated.*¹

*The three most commonly cited options are: awake tracheostomy, awake intubation and intubation following inhalational induction.*² *Patients who were found to have severe stridor or to have a large or vascular tumour endoscopically should have an awake tracheostomy performed under local anesthetic.*²

If the patient is considered possible to intubate, either awake intubation or inhalational induction are possibilities. Awake fiberoptic intubation is an excellent approach to securing a difficult airway. It has been used

*successfully to manage patients with a variety of obstructive lesions.*³ *We disagree with the statement that "awake fiberoptic bronchoscope intubation is totally contraindicated in this scenario". The key to successful awake intubation includes adequate topicalization, patient psychological preparation, experienced fiberoptic operator and full preparation to perform tracheostomy should intubation fail.*^{3,4} *Acute airway obstruction has been reported during awake intubation.*⁵

*Inhalational induction of general anesthesia using sevoflurane is another option.*² *Adequate anesthetic depth must be achieved before airway instrumentation. Complete airway obstruction and laryngospasm can occur during inhalational induction and one should be fully prepared for a tracheostomy.*

*I apologize for an error in Table II.*¹ *Thirty-eight percent of the respondents chose surgical airway, not lighted stylet (erratum published in this issue). It would be inappropriate to use a lighted stylet for an airway with known pathology.*

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References

- 1 *Jenkins K, Wong DT, Correa R.* Management choices for the difficult airway by anesthesiologists in Canada. *Can J Anesth* 2002; 49: 850–6.
- 2 *Mason RA, Fielder CP.* The obstructed airway in head and neck surgery. *Anaesthesia* 1999; 54: 625–8.
- 3 *Ovassapian A.* The flexible bronchoscope. A tool for anesthesiologists. *Clin Chest Med* 2001; 22: 281–99.
- 4 *McGuire GP, Wong DT.* Airway management: contents of a difficult intubation cart. *Can J Anesth* 1999; 46: 190–1.
- 5 *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.