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References

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Reply:

We thank Dr. Dupanovic for his interest in our study. As mentioned in our manuscript,[1] we chose the two stylet angles to be studied based on the most common angulations used by anesthesiologists in our local practice. The distal 60° angulation used at our centre and in the study was heavily influenced by an expert in airway management who described using a stylet shape that closely approximates the shape of the GlideScope® blade.[2] We believe that these are clinically relevant stylet angulations that merit comparison to each other. Based on our study and the observations of others,[3] we believe that the initial stylet configuration for orotracheal intubation using the GlideScope® should be 90°, as described in detail in our study.

We agree that experience is a potential confounding variable in airway instrumentation research, and this emphasizes the importance of randomization to equally distribute potential known or unknown confounders among the groups being studied. Since analyzing times to intubation (TTI) based on experience was not a prespecified secondary outcome (and is therefore subject to the perils related to subgroup analysis),[4] it was with hesitance and caution that we re-analyzed the data to see if experience improved times to intubation in either the 90° or 60° groups (Table). Interestingly, experience of the operator did not seem to influence TTI in the 90° group, but markedly influenced TTI in the 60° group. If anything, this would tend to confirm the conclusion that the 90° stylet configuration is superior to the 60° configuration, especially when dealing with an inexperienced practitioner performing tracheal intubation with the GlideScope® videolaryngoscope.

TABLE Comparison of 90° and 60° degree groups by level of experience

Comparison	*Mean difference (95% confidence interval of difference)*	*P*
90° experienced *vs* 90° inexperienced	- 0.01 sec (-14.85 to 14.83)	> 0.05
60° experienced *vs* 60° inexperienced	-17.1 sec (-30.6 to -3.6)	< 0.01

One-way ANOVA with Tukey-Kramer post test. Calculated in GraphPad Prism version 4.03 for Windows.

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2 *Cooper RM.* Videolaryngoscopy in the management of the difficult airway (letter reply). Can J Anesth 2004; 51: 95–6.
3 *Doyle DJ.* Awake intubation using the GlideScope video laryngoscope: initial experience in four cases. Can J Anesth 2004; 51: 520–1.
4 *Oxman AD, Guyatt GH.* A consumer's guide to subgroup analyses. Ann Intern Med 1992; 116: 78–84.

Airway management for intra-oral surgery - airway first!

To the Editor:
We read with interest the airway management of a patient with an intra-oral dermoid cyst as described by Raveenthiran and colleagues.[1] While the authors should be congratulated for their successful management of an anticipated difficult airway, we seek some clarifications from them. The aspiration of contents of any oral swelling should be preceded by appropriate radiological evaluation, which has not been mentioned. It is not clear whether the large size of the needle used required local or topical anesthesia. It is also not clear if the aspiration was carried out using an extra-oral (e.g., submental) approach. Furthermore, these authors' conclusions and recommendations require a word of caution. Based on the experience from a single case, the conclusions may not be extrapolated to all intra-oral cysts. There are intra-oral