CORRESPONDENCE

Assessment of flexible bronchoscopic intubation through the AuraGain™ laryngeal mask *versus* a slit Guedel tube

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To the Editor,

Moser *et al.*¹ recently assessed the performance of flexible bronchoscopic intubation (FBI) via the AuraGain™ laryngeal mask (Ambu A/S, Ballerup, Denmark) *vs* a slit Guedel tube (Rüsch & Co, Kernen, Germany) in a non-inferiority randomized controlled trial. They showed that FBI through an AuraGain laryngeal mask is achieved at least as rapidly as standard FBI via the slit Guedel tube. Much of their study was well done, and we can learn from their example. We noted, however, an important issue that was not addressed by the authors. The study compared only the times required for FBI via the two studied devices. It did not compare the times required for the whole intubation procedure, which includes inserting each device before FBI, the FBI itself via each device, or removing each device after FBI.

As a commonly used practice to assist FBI, insertion and removal of a slit Guedel tube before and after FBI are evidently easier and simpler than for an AuraGain laryngeal mask, which includes insertion, cuff inflation, position confirmation, cuff deflation, and its removal along the tracheal tube. Especially, removing the AuraGain laryngeal mask after successful intubation without dislodging the tracheal tube from the trachea should be a great challenge to intubators.² As a result, when comparing the performance of FBI via these two devices, in addition to the times required for FBI using each device, the

intubation time should also include the times required for inserting each device before FBI and its removal after FBI. We argue that unrealistic definitions of intubation times for the two groups could make interpretation of their findings questionable.

Furthermore, early postoperative neck pain was used as a performance end point for comparing the two devices, but the readers were not provided with the postoperative pain strategy or the analgesic drug consumption in the two groups. It must be emphasized that when early postoperative neck pain is compared between groups, standardization of postoperative pain management is an essential component of the study design.³ Especially, the timing of analgesic drug administration in relation to the assessment of early postoperative neck pain should be clearly described as part of the method. Because of the lack of comparable postoperative pain management, the study findings and subsequent conclusions must be interpreted with caution as they may have been obtained using incomplete methodology.

Finally, we were interested in knowing why a Unoflex™ reinforced tracheal tube (ConvaTec Ltd, Flintshire, UK) was used for FBI in the AuraGain laryngeal mask group even though it has a fixed connector that could prevent removal of the AuraGain laryngeal mask after successful intubation.⁴

Competing interests None declared.

Editorial responsibility This submission was handled by Dr. Philip M. Jones, Associate Editor, *Canadian Journal of Anesthesia*.

This letter is accompanied by a reply. Please see Can J Anesth 2018; 65: this issue.

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