



Not *which* forceps, but *whether* forceps?

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To the Editor,

I read with interest and would like to comment on the recent randomized clinical trial reported by Yeom et al.¹ regarding nasal intubation using a GlideScope videolaryngoscope (GVL; Verathon Medical Inc., Bothell, WA, USA). In that study,¹ the authors examined the time for nasal GVL intubation using vascular forceps and an airway exchange catheter compared with the standard Magill forceps originally described for direct laryngoscopy.

While I appreciate the notion¹ of a more suitable forceps for GVL nasal intubation, perhaps a better question is whether forceps should be used at all. Previous authors noted the lack of need for Magill forceps when performing nasotracheal GVL intubation and proposed that this explained the observed reduced complication rate with GVL use.^{2,3} This seems intuitive as the Magill forceps was not designed for use with videolaryngoscopy and does not have suitable geometry for this task.¹⁻³ In addition, it is unfortunate that Yeom et al.¹ do not specify the frequency of forceps use in either group of their study, particularly as forceps use (or lack thereof) is part of the intervention being studied. It would be helpful to know if forceps were used in either group.

Since the lack of need for forceps was found in our similarly sized study² a decade ago, I have performed hundreds of nasal GVL intubations, never using forceps of any kind. Similarly, residents I have supervised, after

suitable instruction, have not required forceps use either. Techniques to direct the endotracheal tube (ETT) towards the glottic aperture include micro-movement (i.e., steering) of the neck and slight rotation of the ETT. Once past the cords, gentle 360° rotation of the ETT often “corkscrews” the ETT into the trachea. There may also be significant advantage to using the softer Portex® Polar nasal RAE ETT (Smiths Medical; Dublin, OH, USA), which advances easily and does not require thermal softening. Furthermore, when performing GVL nasotracheal intubation, accepting a more restricted view⁴ is also often helpful since a nasally inserted ETT tends to naturally direct itself to the glottis. Excess anterior distraction of the airway tissues may necessitate forceps use that otherwise would not be required.^{2,3}

Another potential limitation in their study¹ is that it is not clear that the primary (or any other) outcome was blinded in this study, despite multiple previous studies showing viability,² making subconscious bias a concern.

Lastly, I would caution against the study's technique¹ of inserting a nasal ETT prior to verifying a laryngoscopic view,⁵ as potential epistaxis could prove disastrous if an unexpected difficult airway is encountered. Piepho's excellent advice to verify the laryngoscopic view⁵ prior to nasal ETT insertion should be followed with any intubation technique.

In summary, practitioners should consider neck micro-movements, accepting an “adequate” (not perfect) view, and slight rotation of the ETT to avoid the use of forceps, and their attendant complications, during nasal GVL intubation.

Conflict of interest None declared.

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

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