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CORRESPONDENCE

In reply: Awake tracheal intubation: what can be done to maintain the skill?

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To the Editor,

We thank Drs Mirrakhimov and Torgeson for their interest in our article and appreciate the opportunity to respond.[1] As observed in their letter, we found that a decrease in the use of awake tracheal intubation (ATI) had occurred during the years 2014–2020 at our institution.[2] This contrasted with a previous study we had published that looked at the years 2002–2013, in which we did not observe any decrease in the use of ATI (despite increasing use of videolaryngoscopy [VL]).[3] Regardless, any role of VL in decreasing the use of ATI will likely never be more than an observed association, rather than proven causation. Introduced in the early 2000s, if increasing use of VL is indeed found to be associated with decreasing use of ATI, the differing findings of our two studied time periods might suggest a latency of one to two decades before clinicians had developed sufficient trust in the efficacy of VL to decrease their use of ATI.

Drs Mirrakhimov and Torgeson advocate for the need to maintain skills in flexible endoscopy for the purpose of ATI, and we wholeheartedly agree. Nonetheless, as illustrated by their cited article by Rosenstock *et al.*[1,4] and a subsequent meta-analysis on the topic by Alhomary *et al.*,[5] one cannot ignore the evolving evidence that VL can be used for ATI in select topically anesthetized and sedated difficult airway patients. Thus, once a decision for ATI has been made, and assuming equally effective airway topicalization and systemic medication administration either way, the best device for the ATI itself must then be determined: flexible endoscopy or VL. We submit that salient considerations in that determination might include: 1) the patient's presenting anatomy (some presentations may preclude access to the mouth with a VL blade; others may require a flexible endoscope during tracheal intubation to assess the lower airway for penetrating injury, as two examples); or 2) given that some of the most difficult anatomic presentations (e.g., severely limited mouth opening and pathologically enlarged or superiorly displaced tongue) often require nasal flexible endoscopic ATI, the clinician may elect to perform *all* ATIs with flexible endoscopy to help maintain skills with the device. Conversely, other presentations might easily allow for use of either device (e.g., the critically ill patient with *no* anatomic predictors of technical difficulty undergoing ATI chiefly to avoid exacerbating adverse physiology). Finally, certain presentations managed with a "niche" technique might require the use of VL during ATI, e.g., placement of a very small tracheal tube though a highly obstructed laryngeal inlet.[6]

Ultimately, provided the clinician has adequately thought through a decision on which device to use and is prepared with a plan should the technique be unsuccessful, it is likely that VL can safely be used for at least some clinical presentations that require ATI.

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