

An Airway which Facilitates intubation with a Fiberoptic Laryngoscope

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Letter to Editor

Fiberoptic laryngoscope (FL) is often used when there is the probability of difficult intubation. In addition to facilitating intubation it also reduces the risk of laryngoscope-induced complications such as trauma and airway edema. It is mostly utilized when the patient is awake and under the influence of local anesthesia and mild sedation; this is because by reserving spontaneous respiration, besides maintaining adequate oxygenation it facilitates fiberoptic laryngoscopy and intubation(1).

In some cases due to the lack of patient cooperation or discovering a difficulty in intubation during laryngoscopy, it is done under general anesthesia. In such conditions because of muscular relaxation and tongue retraction, in addition to the risk of hypoxia during laryngoscopy, working with FL becomes harder and will not give a clear visual pathway; especially when oral intubation is the case.

In such circumstances in order to lift the tongue and prepare a clear visual pathway it is better to use an oropharyngeal airway (such as Williams, Ovassapian or Bermann II) or an intubating LMA. In this aspect we introduce a new type of airway which facilitates fiberoptic laryngoscopy and

endotracheal intubation. This airway is a modified type of the common oropharyngeal airway, which its right side is dissected (Fig1). In an anesthetized patient after inserting the airway into his mouth and fixing it in the middle line, the fiberoptic laryngoscope is guided downwards through its tube (Fig 2). After seeing the terminal section of the airway it is advanced 1-2 cm further till the glottis comes into view, passes by it and reaches the carina; then the fiberoptic laryngoscope cord is released from the right side of the airway which has been dissected (Fig 3) and the airway is taken out of the patient's mouth.



Fig 1. The shape of the device with a right-sided groove.

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Afterwards, the endotracheal tube which the fiberoptic laryngoscope has been initially placed in is gently inserted in the trachea and the fiberoptic laryngoscope is then removed.

This technique was performed on many patients and resulted in highly facilitated fiberoptic laryngoscopy and intubation. The major positive point of using this airway is that it could be prepared in any operating room with consuming very little amount of time.



Fig 2. The device while the laryngoscope comes through it.



Fig 3. Extraction of the laryngoscope from the right-sided groove device.

References:

1. John Henderson. Airway management in the adult. Miller's anesthesia. 7th ed. 2010: 1592-4.