The laryngeal mask airway and intubating laryngeal mask airway have previously been described for use in ankylosing spondylitis.[3] I report the successful intubation of a patient with a difficult airway secondary to ankylosing spondylitis. The unique feature is that despite being an experienced laryngoscopist, the anesthesiologist was a relative novice to the GVL. The learning curve with this device appears to be rapidly attainable.[1,4] Ideally, the beginner to the GVL may want to first practice its use in manikins. It is suggested that the skills required in using the GVL be acquired in patients with normal airways, before advancing to the difficult airway.

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The author has no commercial interest in the GlideScope® or Saturn Biomedical Systems.

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Parker Flex-Tip tube for fibreoptic nasotracheal intubation in a case of lingual tonsil hypertrophy

To the Editor:
Fibreoptic tracheal intubation is useful for difficult airways. Two major difficulties with this technique are: insertion of the fibrescope into the trachea and then, advancing the endotracheal tube (ETT) over the fibrescope.[1] This second difficulty is attributed to catching of the ETT on supraglottic structures.[2] The Parker Flex-Tip™ tube (PFT; Parker Medical, Englewood, CO, USA) overcame this difficulty in a case of lingual tonsil hypertrophy (LTH).

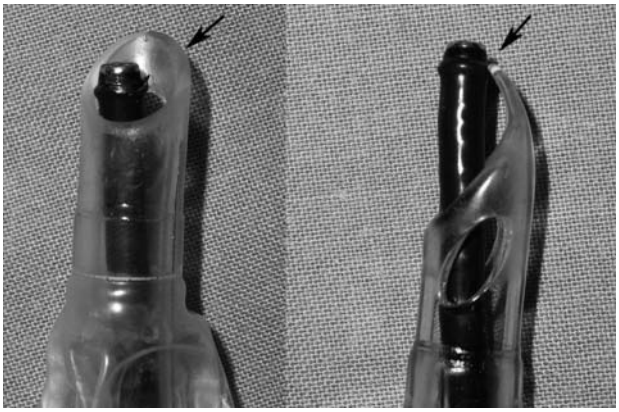

FIGURE Reduction of the gap between the Parker Flex-Tip tube (left) and the fibrescope compared with the Mallinckrodt standard tube (right).

A 56-yr-old previously healthy woman was scheduled for hemithyrodectomy. There was no indication of a difficult airway. After induction of anesthesia, laryngoscopy revealed a grade 4 Cormack Lehane view. The intubation was impossible. We decided to waken the patient and try nasotracheal fibreoptic intubation. A 6.5-mm internal diameter (ID) standard tube (Hi-Contour™, Mallinckrodt Medical, Ireland) was inserted over the fibrescope (Pentax, 3.5-mm outer diameter). The fibrescope was successfully directed into the trachea, but the ETT would not advance, so the procedure was abandoned. A few days later, the patient was monitored and prepared following our standard nasotracheal fibreoptic intubation protocol. We chose a 6.5-mm ID PFT. As the fibrescope advanced a LTH was discovered, narrowing between the epiglottis and the posterior pharyngeal wall. Once the carina was visible, the PFT was easily displaced over the fibrescope into the trachea.

Supraepiglottic masses, like LTH, are recognized risk factors for unanticipated failed tracheal intubation.[3] LTH may also cause massive bleeding following instrumentation of supraglottis[4] and in the worst possible case it may become a "cannot-intubate-cannot-ventilate" situation. In our case, LTH could be the cause of a difficult advancement of the tube.

The major reason for difficulty in advancing an ETT over a fibrescope is impingement of the tube's tip in different parts of the supraglottis;[1] this can be markedly reduced by using a flexible tube. Ovassapian *et al.*[3] studied 33 patients with unanticipated failed intubation, via direct laryngoscopy. LTH was discovered in all patients.

Kristensen reduced two-thirds the rate of resistance to passage of the tube into the trachea by comparing the PFT with the standard tube (Portex™) during fibreoptic orotracheal intubation.[5] Utilization of thinner fibrescopes, or greater ID tubes is possible because the PFT mainly reduces the gap between the scope and the tube (Figure). Reduction of the gap, joined to the use of flexible tubes are the main recommendations given by Asai *et al.*[1]

In conclusion, the PFT tube may be useful for nasotracheal fibreoptic intubation in awake patients.

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Adopting ultrasound to facilitate central venous catheterization

To the Editor:

We commend Drs. Saxena and Sharma for their forthright report of yet another complication related to central venous catheterization (CVC).[1] In response to their query, we believe the most central question is when, if ever, will the use of ultrasound (US) to guide CVC become commonplace, if not the standard of care. The literature is abundant on this topic. Guiding CVC with US results in fewer needle passes, less time to complete the procedure with a higher success rate and fewer carotid punctures. On the other hand, anatomic landmarks, the traditional approach to CVC, are too variable to allow similar results.[2] In addition, determining the size of the internal jugular vein and its relationship to the carotid artery, which is crucial to avoid complications, cannot be accomplished without US. While the use of US for CVC has not been studied in all conditions and circumstances (e.g., cardiac arrest), there is little reason to suspect that clearly depicting the anatomy with US would not compare favourably to "blind" techniques.

The Agency for Healthcare Research and Quality recently assessed 79 medical practices and deemed 11 of them to have sufficiently strong evidence supporting specific recommendations.[3] One of these was the recommendation that US be used for CVC. The recently published closed-claims analysis of complications related to CVC suggests that malpractice suits related to vascular access are increasingly more common than claims related to vascular use/maintenance.[4] Nevertheless, for a variety of reasons, the vast majority of clinicians do not use US for CVC. Ultrasound devices are commonplace in medicine, and not prohibitively expensive, so availability is at most only part of the problem. The greater problem, we believe, is that the adaptation of practice approaches such as the use of US for CVC, which are supported by sound and convincing evidence, will remain a chief challenge in contemporary medicine.

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