



## In reply: Comparing devices for managing the difficult airway

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Received: 26 September 2023 / Revised: 26 September 2023 / Accepted: 26 September 2023 / Published online: 2 November 2023  
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**Keywords** airway management · bougie · intubation ·  
laryngoscopy · Vie Scope

### To the Editor,

We thank Bhakta *et al.*<sup>1</sup> for their interest in our work<sup>2</sup> and for emphasizing the importance of the epiglottis–blade interaction in the management of difficult tracheal intubation.

Our study compared a curved-blade videolaryngoscope with the Vie Scope® (Adroit Surgical LLC, Oklahoma City, OK, USA) as a straight-blade anterior commissure laryngoscope necessitating bougie-facilitated intubation in a two-step approach. Although the Vie Scope is a conventional laryngoscope that provides a direct view of the glottis, it has been suggested as a substitute for videolaryngoscopes, for example in emergency medicine.

The idea behind our studies was to test the novel Vie Scope device against the clinical standards, Macintosh laryngoscope<sup>3</sup> and Macintosh videolaryngoscope,<sup>2</sup> which are typically used for laryngoscopy in many departments. In our opinion, this was the most reasonable comparison for evaluating efficacy and safety of this novel device.

Bhakta *et al.*<sup>1</sup> highlight a crucial point that restricted glottis movement might substantially impair the view of the glottis during laryngoscopy and that indirect or direct

glottis lifting plays a key role in difficult airway management. While Macintosh videolaryngoscopy relies on indirect epiglottis lifting by point pressure on the hyoepiglottic ligament in the vallecula, straight-blade techniques rely on direct epiglottis lifting by placing the blade's tip beneath the epiglottis and close to the anterior commissure. Nevertheless, it has been proposed that direct epiglottis lifting can also be performed with laryngoscopy approaches other than straight-blade techniques (e.g., with Macintosh blades), but this is currently underreported.<sup>4</sup> Most recently, the first prospectively developed universal classification for videolaryngoscopy (the VIDIA score) has been published including these important aspects of impaired epiglottis movement and direct epiglottis lifting for the grading of difficult videolaryngoscopic intubation.<sup>5</sup>

We acknowledge that we compared a two-stage bougie-facilitated approach against a one-stage approach, but this reflects the devices' intended uses and we believe that any new device should show its noninferiority against current clinical practice.

We agree that knowledge gaps regarding the Vie Scope remain, and we encourage Bhakta *et al.* to conduct further studies comparing the Vie Scope against videolaryngoscopes with different types of blades (e.g., straight or hyperangulated) and also against other bougie-facilitated approaches. This would add to our knowledge of anterior commissural laryngoscopy and provide further valuable insights into airway management.

From our studies, we conclude that the Vie Scope provides a good view of the glottis, but because of the two-step bougie-assisted approach, this does not translate into better or faster tracheal intubation compared with Macintosh laryngoscopy or Macintosh videolaryngoscopy.<sup>2,3</sup>

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**Disclosures** Martin Petzoldt has received a study grant from Verathon Inc., Bothell, WA, USA. Tim T. Hardel has received research support from Drägerwerk; Jörn Grensemann has received research support from Ambu and ETVIEW, and consultant fees from Drägerwerk and GE HealthCare. The other authors declare no conflicts of interests.

**Funding statement** Open Access funding enabled and organized by Projekt DEAL. The study was funded from departmental resources with the Vie Scopes kindly provided free of charge by the distributor.

**Editorial responsibility** This submission was handled by Dr. Stephan K. W. Schwarz, Editor-in-Chief, *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*.

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