

## Références

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## *Styletted orotracheal intubation in difficult airway management*

To the Editor:

The recently-published continuing medical education module: “Advances in Airway Management” summarizes a variety of techniques and specialized equipment intended in part as rescue measures following failed endotracheal intubation.<sup>1</sup> In their article, Drs. Hung and Law do not discuss reasons why other devices developed as solutions to the unanticipated difficult airway have waxed and waned over the years. A partial explanation justifying development of rescue devices, both past and present, stems from the assumption that improvement to “textbook” intubation is no longer possible, and therefore the only viable alternative is to create new products to deal with the difficult airway. Many “difficult intubations”, in fact, are the consequence of technical shortcomings of standard orotracheal intubation, a technique that from its inception was intended only to secure the airway in most, but not all patients. Continued use in its relatively unchanged form for nearly a century has proven that the current procedure fails in approximately 10% of first try intubations when laryngoscopic orotracheal intubation is the appropriate approach. Despite having identified and recognized failures as being unpredictable in some patients, the anesthesia community continues to advocate a technique that in critical situations is time consuming and may eventually have to be supplanted by another method of airway management.

Another approach is to identify why textbook intubation fails in difficult circumstances, and to introduce

an improved *system* of routine intubation which may yield equal or better results than achieved with many airway devices promoted for managing the difficult airway, and one that accomplishes intubation of the trachea in a significantly shorter time. These criteria may be met by incorporating a clinically proven method of stylet intubation into routine practice.<sup>2</sup> Routine use of stylet intubation would in no way undermine to need to search for new tools to improve airway rescue, but, to the patient’s benefit, would reduce the need for ancillary equipment in managing the difficult airway. The described system of stylet intubation is effective because when used correctly as an integral component of a multi-stepped technique of orotracheal intubation, it functions as an advanced airway management device that permits controlled positioning of the endotracheal tube tip at the glottic opening during both easy and difficult laryngoscopy.

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## References

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- 2 Stasiuk RB. Improving stylet oral tracheal intubation: rational use of the OTSU. *Can J Anesth* 2001 48: 911–8.

## *Reply:*

*We thank Dr. Stasiuk for his interest in our continuing medical education (CME) program and are grateful for the opportunity to reply. The objective of the CME program was to review recent advances in methods of oxygenation and ventilation. We absolutely accept that every effort should be made to maximize the chances of first attempt intubation success. As previously emphasized by other authors, factors contributing to this success using direct laryngoscopy (DL) include ensuring proper positioning and muscle relaxation; use of an appropriate blade; external laryngeal manipulation;<sup>1</sup> head lift;<sup>2</sup> and the tracheal tube introducer (TTI) (e.g., Eschmann Tracheal Tube Introducer) or a fiberoptic stylet<sup>3</sup> as adjuncts to laryngoscopy. As Dr. Stasiuk points out, difficult DL situations will continue to be encountered, even after applying optimal techniques, due to anatomic variations or pathologic changes of the upper airway. Far from accepting this in an ‘unquestioning manner’, we contend that the anesthesia and airway management*