



In reply: Parallel intubation technique with the Vie Scope[®] laryngoscope

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To the Editor,

We thank Dr. Henlin *et al.*¹ for their interest in our work² and for sharing their interesting insights into the “parallel intubation technique.” We are pleased that the authors’ experience is consistent with our previously published study results^{2,3} suggesting that glottis visualization with the Vie Scope[®] (Adroit Surgical LLC, Oklahoma City, OK, USA) is superior to direct laryngoscopy and noninferior to Macintosh videolaryngoscopy, despite increased time-to-intubation.^{2,3} In our opinion, the good visualization achieved with the Vie Scope is primarily due to direct epiglottis lifting, being a key element of straight-blade techniques and also significantly improving the glottis exposure in difficult Macintosh videolaryngoscopy.⁴

Nevertheless, some potential disadvantages of the Vie Scope must be considered:

- 1) The Vie Scope is designed to be used in a two-step bougie-assisted approach that prolongs time-to-intubation compared with a direct approach.^{2,3}
- 2) The tracheal tube is railroaded over the bougie without visualization of the laryngeal inlet; therefore, tube

advancement cannot be visualized and tube impingement on the anterior commissure or arytenoids cannot be visually confirmed.³

- 3) Correct bougie placement may not be verified through the Vie Scope in situations with significantly restricted glottis view through the channel (i.e., grade 2C or worse);^{4,5} in our previous study, we observed four unintended esophageal intubations in patients with expected difficult airways² probably due to bougie misplacement.

The “parallel intubation technique” suggested by Henlin *et al.* is very promising for avoiding “blind insertion” of the tracheal tube over the bougie and could furthermore identify a bougie misplacement before the tracheal tube is advanced. Nevertheless, this method retains a two-step approach with an inherently longer time-to-intubation. It must be considered that this technique changes the alignment between bougie and tracheal inlet; therefore, the straight bougie supplied by the manufacturer might not be suitable and a J-shaped bougie may be more appropriate. Nevertheless, this technique is not outlined by the manufacturer and no data are available so far. In our opinion, a study is required to investigate the feasibility, safety, and efficiency of this novel approach.

Thus, there are currently four described options for using the Vie Scope: 1) the median approach, 2) the paraglossal approach, 3) Vie Scope-guided tube placement (after bougie placement and reinsertion of the Vie Scope), and 4) the parallel approach, suggested by Henlin *et al.* In our opinion, all these approaches should be further investigated to enable a more context-dependent and personalized use of the Vie Scope tailored to the individual patient and specific clinical situation.

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