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Considerations aimed at facilitating the use of the new GlideScope® video-laryngoscope

To the Editor:

The GlideScope® videolaryngoscope (Saturn Biomedical System Inc., Burnaby, BC, Canada) can exceed the utility of other instruments formerly considered indispensable in cases of foreseen difficult airway.^{1,2} On the basis of our experience with this device, which includes 200 patients to date, we would like to offer a series of considerations:

1) Following difficulties to appropriately insert the laryngoscope blade when we began to use the device, we decided to modify the insertion technique in such a way as to use the instrument like a Guedel tube; that is, to insert the blade in the patient's mouth with the concave side looking up, before turning it 180° anticlockwise from the left to the right, to set it in place in the pharynx. This makes it possible to displace the tongue to the left and to minimize neck mobilization, while also allowing use of the device in cases of moderately limited mouth aperture.

2) "Steaming up" occurs to a greater or lesser degree. In our experience, optimal vision can be ensured with the GlideScope® by immersing the blade area containing the camera in lukewarm water for a few minutes before using the device.

3) We agree with Dr. Cooper³ that the main problem of intubation with the GlideScope® has to do with passing the endotracheal tube (ETT) through a glottis that is in full view; this is because the lens invades the

blade channel. We have managed to solve this problem by using a thick, firm, 5.6-mm stylet. We also angulate the tube a little more than 60°. The ETT should be inserted with the concave side up, and must be turned clockwise from right to left while it is slid behind the videolaryngoscope, in such a way that it fits in between the device and the pharynx. This positions the tip of the ETT under the tip of the blade, and aims it correctly in the direction of the glottal orifice. Intubation difficulties with this device sometimes occur because the tip of the ETT collides with the anterior commissure of the glottis, a problem that can be minimized by turning the tube while it is inserted. On two occasions we solved this problem using a Fastrack® laryngeal-mask tube (LMA North America Inc., San Diego, CA, USA), which has a blunter tip than a conventional ETT. In both cases, we were able to slide it through the glottis easily, without causing trauma.

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- 3 *Cooper RM.* Videolaryngoscopy in the management of the difficult airway (Letter, reply). *Can J Anesth* 2004; 51: 95–6.

REPLY:

I am grateful for the opportunity of responding to the interesting letter from Drs. Cuchillo and Rodríguez.

Two recent publications are consistent with their comment that this device frequently provides comparable, but more frequently superior laryngeal exposure than direct laryngoscopy.^{1,2} However, it may be difficult to introduce the laryngoscope blade into the mouths of patients with limited atlanto-occipital extension, reduced interincisor distance and/or a very protuberant chest. Their suggestion of introducing the laryngoscope upside down and rotating it as with a Guedel airway has not been previously described, and may prove helpful.

I am surprised by their comment concerning a foggy image. The transparent glass protecting the videochip is