



FIGURE Fiberoptic bronchoscopic view of laryngeal opening in an elderly patient with hoarseness of voice showing bilateral Reinke's edema, more on the left.

a complication following prolonged tracheal intubation. Patients with unsuspected RE can present airway obstruction under anesthesia.³

The treatment of RE may be conservative, treating the GERD with medications (omeprazole), stopping smoking and reducing voice abuse. The surgical treatment consists of excising the lesions, medialization laryngoplasty for vocal cord paresis, and excision of the superficial lamina propria of the vocal folds by surgery or CO₂ laser technique.^{4,5}

We have managed two patients with RE. In both cases we could identify the polypoid appearance of the vocal fold (Figure) during laryngoscopy. We provided anesthesia for laryngoscopy or laryngoscopic surgery with propofol induction and succinylcholine muscle relaxation for tracheal intubation, using a smaller 6 or 7 mm internal diameter endotracheal tube with ease. We maintained anesthesia with sevoflurane, oxygen and air and provided muscle relaxation with mivacurium. Following tracheal extubation we administered *iv* dexamethasone 10 mg and recemic epinephrine inhalation treatment (racepinephrine 0.5 mL in 3 mL of normal saline in nebulizer) for glottic edema. Neither patient experienced airway complications, and both recovered uneventfully.

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Dexmedetomidine is a useful adjunct for awake intubation

To the Editor:

Awake intubation in the patient with a potentially difficult airway is a stimulating procedure which may be associated with wide hemodynamic changes. To attenuate this response, blunting of airway reflexes is required without losing the patient's cooperation. Dexmedetomidine (DEX), a highly selective α_2 agonist, has the unique property of sedating and providing analgesia without affecting the patient's respiration.^{1,2} It has been successfully used for attenuating the stress response to laryngoscopy.³ We report a patient in whom DEX with topical anesthesia provided favourable conditions for awake fiberoptic intubation. After approval by the Board of Studies, informed consent was obtained.

A 62-yr-old ASA II patient (175 cm, 64 kg) with faciomanibular abnormalities secondary to an old gunshot wound was scheduled for plastic facionasal reconstruction. His preanesthetic airway evaluation revealed a mouth opening of 1 cm, and a distorted nasal septum with patent left nasal passage.

Awake fiberoptic intubation was planned. DEX 1 mg·kg⁻¹ *iv* diluted to 10 mL with 0.9% normal saline

was given over ten minutes. Four percent lidocaine oral gargle and nebulization was used to anesthetize the oral cavity and supraglottic area. In addition, bilateral superior laryngeal nerve blocks were performed. A 7.0-mm internal diameter endotracheal tube (ETT) was pre-mounted over the fibroscope. Flexible fibroscopy was done via the left nostril with a continuous flow of 3 L·min⁻¹ oxygen through the suction port. It required 40 sec for maneuvering the fibroscope to visualize the carina. While the ETT could not be railroaded on the first attempt, a slight rotation of the ETT and a deep breath facilitated its correct placement in the trachea. The whole procedure took about 100 sec, with the patient remaining awake and responsive to command throughout.

During the awake intubation, the patient's SpO₂ remained between 97% and 99%. The heart rate varied from 88 to 96 beats·min⁻¹ and maximum systolic blood pressure was 124 mmHg, a rise of 16 mmHg from the immediate pre-fibroscopy value. The next day, the patient described his experience of fibroscopy procedure as only mildly uncomfortable. We believe that DEX 1 mg·kg⁻¹ *iv* contributed to the stability of the hemodynamic course during this brief, but intense procedure.

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Successful first time use of the portable GlideScope® videolaryngoscope in a patient with severe ankylosing spondylitis

The GlideScope® videolaryngoscope (GVL; Saturn Biomedical Systems Inc., Burnaby, BC, Canada) was developed for management of the difficult airway. The laryngoscope blade consists of a camera and light source embedded along its inferior aspect.¹ The blade has a 60° angle, and with its camera provides outstanding views of the supraglottic airway and adjacent structures. The airway image is captured on a 7-inch display unit that can accompany this system, or with other compatible designs.^{1,2} The portable GVL is the latest version to be developed. There are several features that make this system appealing. First, it is lightweight. Second, it has a high-resolution screen. Third, it is compact and comes with its own carrying case (Figure).

The portable GVL was recently taken on a medical mission to Pune, India. The consultant anesthesiologists in the hospital observed the use of the GVL, and subsequently gained "hands-on" experience with this system. Shortly after its introduction, one of the consultants used the portable GVL in a patient with severe ankylosing spondylitis. The patient's airway examination revealed a Mallampati class IV, but with adequate mouth opening. Following induction of general anesthesia, the GVL provided a Cormack-Lehane grade 1 laryngoscopic view and permitted, during the first attempt, easy endotracheal intubation with a styletted 7.0-mm internal diameter tube, bent at 90°.



FIGURE The portable GlideScope® videolaryngoscope (reprinted with permission, Saturn Biomedical Systems Inc., Burnaby, BC, Canada).