

Letter to the Editor: Retrograde - Fiberoptic Assisted Intubation

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Abstract

Dear Sir,

Thank you very much for giving us chance to respond to the letter of Narendra Babu volume 9 Number 1 regarding our case report published in your journal volume 8 Number 2.

Dr. Narendra has raised few questions and suggested that Laryngeal Mask Airway (LMA) and Intubating Laryngeal Mask Airway (ILMA) to be used in such cases.

We think that the following lines will clarify more about our case.

We never induced this patient to be asleep or paralyzed. He was breathing spontaneously all the time. He was sedated fairly well preoperatively and was very cooperative and being monitored for haemodynamics and oxygen saturation. Difficult airway was very well anticipated preoperatively.

Being a major case and to be done in lateral position, we thought that an absolute controllable airway should be sought. Anyway, when the flexible fiberoptic bronchoscope was not passed through the vocal cords, no matter how much it was rotated, it was getting stuck either anteriorly or posteriorly. We never have had any such failure that fiberoptic bronchoscope after passing through vocal cords cannot be passed into the trachea. We once even tried to push the endotracheal tube mounted on the fiberoptic bronchoscope but a resistance was encountered and we felt that we might injure the larynx. Thus, the further attempts of negotiating with the fiberoptic bronchoscope intubation were abandoned and retrograde method was selected. A fiberoptic bronchoscope was railroaded on the wire. Since we had already failed to pass the scope through the vocal cords, we wanted to see that the scope could enter the trachea before the endotracheal tube could be safely passed into the trachea.

The patient's larynx, hypopharynx and trachea were very well anaesthetized and he was fully awake and breathing spontaneously with oxygen saturation of 98-99 % throughout the procedure. Once the fiberoptic bronchoscope entered the trachea and tracheal rings were seen then the endotracheal tube was railroaded without any problem.

We think Dr. Narendra would agree that an airway control such as in this case should be secured in a way that no problem should occur during the procedure. We did not try the LMA in this case because the position, time and pathology of the patient. But even if we would have had an LMA we would have put the patient asleep and if we would have lost the airway control we would had to move in trouble for a surgical airway.

In the controlled manner, the way we have managed the airway we were not worried at any moment that we could loose the airway. There was no question of cannot ventilate and cannot intubation scenario in our case. An intubating LMA would have certainly failed because of anteriorly situated larynx. When the fiberoptic bronchoscope could not be passed in trachea, we doubt that the intubating LMA would have helped us.

Dr Narendra is also concerned with the complications of the retrograde method. This is not an adventure at the cost of some one's life. We don't agree with this statement. Dr. Narendra thinks that it is only reserved for emergency protocol. However, in difficult airway, an elective retrograde method of intubation is a common method particular in the units where fiberoptic facilities do not exist. We do not agree with Dr. Narendra that cricothyroid puncture is only for cannot ventilate, cannot intubate scenarios. More over, he objected for using suction port of the fiberoptic bronchoscope. It is not for ventilation and for Dr. Narendra'

s information intubating fiberoptic bronchoscopes are not for biopsy purposes.

We also failed to comprehend why he thinks it should be very quick procedure. In a controlled situation as in our case a well monitored, conscious, spontaneously breathing patient maintaining an SpO₂ of 98-99% why one should worry about a cricothyriod puncture and retrograde wiring and threading the fiberoptic bronchoscope to intubate the patient. It hardly took 7-8 minutes to finish the procedure. We totally refute his statement that it was an adventure at the cost of some one's life. More over, the Difficult Airway Society guidelines are for the management of the unanticipated difficult intubation. Dr. Narendra could not differentiate

between anticipated and unanticipated difficult intubation.

We hope we have cleared the queries of Dr. Narendra well. If he has more questions we will be glad to answer,

Respectfully, the authors

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References

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