

LIST DO REDAKCJI/LETTER TO EDITOR

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Awake tracheal intubation using the Airtraq laryngoscope in difficult airway

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The Airtraq laryngoscope (AL) is a single use indirect optical laryngoscope designed to facilitate tracheal intubation in anaesthetised patients either with normal or difficult airway anatomy. It is designed to provide a view of the glottis without alignment of the oral, pharyngeal and tracheal axes with minimal manipulation of the patient's head.

We report our experience of awake tracheal intubation using the AL with 10 patients scheduled for abdominal surgery with difficult airway, aged between 55 and 85 yr. Six patients presented a Mallampati classification grade III and 4 a grade IV. Thyromental distance was less than 6 cm in 7 patients and greater than 6 cm in 3. All the patients were previously informed and consent was obtained.

After routine monitoring (electrocardiogram, non invasive arterial pressure and pulse oximetry), all patients were sedated with midazolam (1-2 mg IV) and 10% lidocaine spray (3-5 puffs) was applied in the pharynx and back of the tongue. Supplementary oxygen was started through nasal cannula at 3 L.min⁻¹ previous to a remifentanyl infusion at 0,1 mg.Kg⁻¹.min⁻¹ for 10 minutes. The patient's neck was placed in neutral position and the AL blade was inserted a little into the center of the tongue. We considered the patients were prepared to start awake intubation when they had not cough or gag reflex. No more sedation was needed.

Laryngoscopy was slowly performed, looking through the visor, moving the device to identify the epiglottis, placing the tip in the vallecula epiglottica. When the vocal cords were exposed, a 18 Fr suction probe was passed through the endotracheal tube and 4-5 ml of 2% lidocaine were instilled intratracheal. The patient was intubated 30 s after.

We recorded hemodynamic data at the beginning and

just after intubation, observing less than 20% variations over previous values in heart rate and arterial pressure, and less than 5% variations in pulse oximetry values. The mean duration of the laryngoscopy was 2,61 min (90 s to 5 min). Intubation was achieved on the first attempt in 2 patients, in 4 after a maneuver (consisting in AL elevation), 3 patients required more than 2 maneuvers and the technique was abandoned by vomiting in 1 patient, which involved the rapid induction of anaesthesia and intubation via direct laryngoscopy. The patient's satisfaction was very good in 9 cases (excluding the patient who vomited) scored according to a scale ranking from poor, fair, good or very good satisfaction. The anaesthesiologist's satisfaction was poor in 2 cases, fair in 2, good in 3 and very good in 3 patients respectively.

Our results are similar to others [1-3]. These data suggested that AL awake tracheal intubation after an adequate sedation and topical anaesthesia is a good alternative with good tolerance and cooperation from the patient in cases of difficult airway. AL requires a easy learning curve [4], recommended by the manufacturer of two to four times before use in a patient with difficult intubation, so it should be take into account as an alternative to other methods of intubation in the awake patient, such as fiberoptic intubation, not available in all hospitals and with a more laborious learning curve.

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Piśmiennictwo

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Katedra i Klinika Anestezjologii i Intensywnej Terapii Akademii Medycznej we Wrocławiu organizuje I Międzynarodową Konferencję „**Sepsa w Zamku**”, która odbędzie w dniach 17-18 czerwca 2010 r. w Zamku Książ k/Wałbrzycha. Głównymi tematami będą:

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