Dr. Verniquet correctly stated the mechanism by which air in the pleural space disrupts the lung sliding sign. Thank you for that clarification. Dr. Verniquet also made several observations about the diagram that accompanied the ultrasound image. First, it was noted that the pleural line was visible beneath the rib structure. It was suggested that cartilage rather than rib was actually imaged because heavy rib calcification will cast an ultrasonic shadow and make the pleural line not visible. Although this is a possibility, the pleural line is often visible at the edges of known rib images. The second critique concerned the region of the diagram labeled lung parenchyma. Dr. Verniquet indicated that normal air-filled lung is not visible by ultrasound. However, the purpose of the diagram and image was to help interpret the lung sliding sign shown in the video. The major point is that the lung sliding sign implies that lung parenchyma, not pneumothorax, is present in this area. Similarly, the presence of a comet-tail artifact implies the presence of air-filled lung rather than pneumothorax.[2]

We also acknowledge the comments by Dr. Verniquet and Dr. Omar *et al.* that computed tomography rather than chest x-ray is the gold standard for diagnosis of pneumothorax. However, some have described a gold standard to be the best available test rather than the perfect test.[3] From an operating room perspective, timely access to computed tomography of the chest is distinctly limited compared with that of emergency departments and intensive care units. Further, the intraoperative question is to identify a large, compromising pneumothorax. The utility of thoracic computed tomography to identify a small, occult pneumothorax carries less clinical relevance for the operating room patient.[4,5] Therefore, it is arguable that a portable chest x-ray, albeit its lower sensitivity to detect a smaller pneumothorax compared with computed tomography, is the gold standard to image an operating room pneumothorax. Increasing the availability and experience with ultrasound in anesthesia will allow us to rule out potential pneumothorax in clinical practice in a fast and noninvasive manner.

Ken-ichi Ueda, M.D., Alan F. Ross, M.D., Waseemuddin Ahmed, M.D.,* *University of Iowa, Iowa City, Iowa. waseemuddin-ahmed@uiowa.edu

References

1. Ueda K, Ahmed W, Ross AF: Intraoperative pneumothorax identified with transthoracic ultrasound. ANESTHESIOLOGY 2011; 115: 653–5
2. Lichtenstein D, Mezire G, Biderman P, Gepner A: The comet-tail artifact: An ultrasound sign ruling out pneumothorax. Intensive Care Med 1999; 25:383–8
3. Versi E: "Gold standard" is an appropriate term. BMJ 1992; 305:187
4. Ball CG, Kirkpatrick AW, Laupland KB, Fox DL, Litvinchuk S, Dyer DM, Anderson IB, Hameed SM, Kortbeek JB, Mulloy R: Factors related to the failure of radiographic recognition of occult posttraumatic pneumothoraces. Am J Surg 2005; 189: 541–6, discussion 546
5. Ball CG, Kirkpatrick AW, Laupland KB, Fox DI, Nicolaou S, Anderson IB, Hameed SM, Kortbeek JB, Mulloy RR, Litvinchuk S, Boulanger BR: Incidence, risk factors, and outcomes for occult pneumothoraces in victims of major trauma. J Trauma 2005; 59:917–24, discussion 924–5

(*Accepted for publication December 30, 2011.*)

Endotracheal Intubation Is Not Always Easy

To the Editor:

I read with interest the recent case published in ANESTHESIOLOGY titled "Intermittent Airway Obstruction in a Neonate" by Schwartz *et al.*[1] The main purpose of the publication was to show images of the cystic supraglottic lesion responsible for airway compromise and the images before and after surgical management. However, I could not help but notice that the authors described the intubation as "easily accomplished with direct laryngoscopy." They describe the mass involving not only the base of the tongue, but also the epiglottis and the glottis opening. The images show a Cormack-Lehane grade 3 view[2] that corresponds to a percentage of glottic opening (POGO) score of 0%,[3] a "restricted" or "difficult" view in the Cook classification (we do not know exactly because there is no mention whether the epiglottis could be lifted during direct laryngoscopy).[4] Usually these conditions are not conducive to "easy" laryngoscopy or intubation procedures. There are cases when one may predict and encounter difficult laryngoscopy and there is no difficulty performing the actual intubation (*e.g.*, blind intubation) and occasions when laryngoscopy is easy and the intubation difficult (*e.g.*, subglottic stenosis), but these cases are rare, and the usual occurrence is that if there is a limited laryngeal view, intubation requires multiple attempts, providers, and devices, and there is greater potential for complications; the procedure is far from being considered "easy" and in fact may well be impossible.

Felipe Urdaneta, M.D., University of Florida College of Medicine and the Malcom Randall Veterans Administration Medical Center, Gainesville, Florida. furdaneta@anest.ufl.edu

References

1. Schwartz AJ, Javia L, Stricker PA, Nadeau P, Nguyen C: Intermittent airway obstruction in a neonate. ANESTHESIOLOGY 2011; 115: 630
2. Cormack RS: Cormack-Lehane classification revisited. Br J Anaesth 2010; 105:867–8
3. Ochroch EA, Hollander JE, Kush S, Shofer FS, Levitan RM: Assessment of laryngeal view: Percentage of glottic opening score *vs* Cormack and Lehane grading. Can J Anaesth 1999; 46:987–90
4. Cook TM: A new practical classification of laryngeal view. Anaesthesia 2000; 55:274–9

(*Accepted for publication December 28, 2011.*)