

with the Airway Intubator<sup>®</sup>. Incidentally, only the lateral margins of this airway actually come in contact with the tongue; consequently, it is more readily accepted by the awake patient with minimal topical anesthetic preparation.

R. TUDOR WILLIAMS  
Assistant Clinical Professor  
Department of Anaesthesia  
Foothills Hospital at the University of Calgary  
Calgary N.W.  
Canada

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*In Reply:*—We welcome the comments made by Drs. Stewart, Ellis, and Williams. Although we have never experienced any problems using the Flexi-lum<sup>®</sup> surgical light, we agree with the recommendation by Drs. Stewart and Ellis that the TUBE-STAT<sup>®</sup> intubating stylet be used in place of the Flexi-lum<sup>®</sup> surgical light for lightwand intubations. The TUBE-STAT<sup>®</sup> was not yet available when we began our study.

Ellis *et al.* found the lightwand method of endotracheal intubation to be comparable with direct laryngoscopy in patients who have been given muscle relaxants.<sup>1</sup> Our investigation emphasized the advantages of lightwand orotracheal intubation over blind nasotracheal intubation in awake patients. Particular emphasis was placed upon the utility of this technique in the patient with a known or suspected difficult airway. Most anesthesiologists would elect not to paralyze these patients until the airway has been secured.

Dr. Williams takes issue with our suggestion that blind nasotracheal intubation requires a spontaneously ventilating patient.<sup>2</sup> We did not mean to imply that blind nasotracheal intubation is impossible in an apneic patient. However, the standard of practice at our hospital is to perform the intubation with the patient either awake or anesthetized with spontaneous respiration. Muscle relaxants are used only if the glottis is to be directly visualized. A review of several standard anesthesia textbooks produces no discussion of, and certainly no advocacy for, blind nasotracheal intubation in the patient who has received muscle relaxants. Indeed, Stoelting states that “. . . maintenance of spontaneous ventilation of the lungs is essential to identify the glottic opening” for blind nasotracheal intubation during anesthesia.<sup>3</sup> Collins states that “It is generally required . . . that the patient be breathing spontaneously” and “(O)ther requirements for

successful blind intubation are hyperpnea and intubation during expiration.”<sup>4</sup> Obviously, these conditions do not exist in a patient who has received muscle relaxants. We draw attention to the comments of these authors, not to dispute Dr. Williams' record of success with this technique, but to emphasize that our suggestion is consistent with the current standard of practice.

There are many ways to approach the patient with a difficult airway. The oral lightwand is a useful technique which is easily mastered.

DONALD J. FOX, M.D.  
Chief Resident in Anesthesiology  
Letterman Army Medical Center  
Presidio of San Francisco, California

ALAN J. RASTRELLI, M.D.  
Staff Anesthesiologist  
St. Joseph's Hospital  
Denver, Colorado

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