"difficult intubation" for a thoracotomy at another institution 1 yr previously. Room air oxygen saturation was 90%, which increased to 97% with a mask that partially fit the patient's mouth. An arterial catheter was inserted.

The induction plan was to use oral topical anesthesia with 10% lidocaine spray and to try awake laryngoscopy first, to avoid tracheotomy if possible. No intravenous sedation was given. During attempted laryngoscopy with the Macintosh and Miller blades, no pharyngeal structures except the base of the tongue could be identified. The Jackson laryngoscope (with a xenon light source) was introduced from the left side, displacing the tongue to the right, and clearly showed the vocal cords.

A 6-mm endotracheal tube (ETT) without the connector, with a stylet protruding 1 cm from its end, was introduced inside the scope. Once below the cords, the cuff was inflated, and while the stylet was being held, the scope was gently withdrawn while an assistant held the ETT deep in the pharynx. Dislodgement of the ETT was minimized because it was reasonably anchored by the inflated cuff and the stylet was in place. The procedure lasted less than 2 min without any major discomfort to the patient.

Fiberoptic oral intubation would have been the obvious second choice if direct laryngoscopy had failed. Retrograde wire intubation must be done blindly and might have induced bleeding in the nasopharynx in this patient. Either one of these techniques would have required more time than the Jackson laryngoscope to accomplish the intubation.

In addition, this tubular-type laryngoscope is more readily available in any operating room area as compared to an apparently improved version.5

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**REFERENCES**


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**J-wire Facilitates Translaryngeal Guided Intubation**

To the Editor—In a description of retrograde techniques for tracheal intubation,1 Benuomf states, “the retrograde guide may be either a guidewire or any type of small-diameter luminal catheter that has a standard hub on the end of it.” Several technical problems have prevented general use of this method: 1) the catheter does not pass easily through the vocal cords; 2) it is hard to see a luminal catheter in the oropharynx because of its transparency; and 3) it is difficult to pick up the catheter or a standard guidewire in the oropharynx without damaging the mucosa of the area.

To solve these problems, I have proposed the use of a J-wire, as used for central venous catheterization.2,3 The "J" shape of the wire allows easy entrance between the vocal cords without injury. With the "J" already in the oropharynx, a rotary motion around its axis produces an obvious and easily perceptible displacement within the oral cavity, which facilitates its location. At the same time, separating the tip of the wire from the mucosa makes it easier to pick it up by forceps, thereby decreasing the likelihood of mucosal trauma. I believe that this simple modification can increase the popularity of translaryngeal guided intubation among anesthesiologists.

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**The Belscope for Management of the Difficult Airway**

To the Editor—In response to Benuomf’s excellent article,1 I would like to make a few observations regarding the Belscope,2 an angulated laryngoscope blade (fig. 1), particularly with respect to the three points of reservation discussed.

The Belscope is a unique device, having a right-angled bend where the handle meets the blade of the laryngoscope. It allows the laryngoscope to be easily passed between the vocal cords, avoiding the tip of the blade from touching the mucosa. This feature makes it easier to intubate patients with difficult airways.

First, it has probably not been widely evaluated because it has either not been readily available (e.g., hidden away on a difficult intubation cart) or has not been purchased at all. I believe it should be more readily available for practice and training purposes, and therefore be

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of use when encountering difficult airways, whether predicted or un-
expected. In more than 250 intubations to date using the angulated
blade (unpublished data), I have encountered 12 grade 3 laryngoscopies
according to Cormack and Lehane's classification using the Macintosh
blade (having deliberately sought out difficult cases for the purpose of
comparison between the two). Laryngoscopy in all 12 cases provided
a good view of the vocal cords, and in only 4 of these was an introducer
required in the endotracheal tube to achieve intubation. Use of the
detachable prism was not required on any of these occasions.

Second, regarding the time commitment in acquiring skill with the
angulated blade: it will attach to most standard laryngoscope handles
and can therefore be readily available for practice in routine cases.
Apart from the classical difficult case, the angulated blade is also very
useful where awkward or poor dentition exists, because the proximal
part remains well away from the upper teeth during both laryngoscopy
and intubation.

Third, regarding the prism available for use with the Belscope and
the problem of "fogging": there are several ways to avoid this. The
prism can be kept either alone, or ready-mounted on a spare blade in
dry swabs or cotton wool in a known blanket-warming or similar cup-
board, or an antimisting preparation can be used. Also available is a
waxlike spectacle antimisting stick (which does require the prism to
be polished prior to use).

I have not used the other new laryngoscope designs referred to in
Benumof's paper, but from my experience with the Belscope, I would
certainly recommend it as having an easy "learning curve" and as a
reliable and most useful instrument.

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In Reply—l completely agree with Kleinman that it is a very im-
portant responsibility of the anesthesiologist to administer appropriate
follow-up care to a patient whose airway was difficult to manage. In
fact, the American Society of Anesthesiologists (ASA) Task Force on
the development of an ASA guideline for the management of the dif-
fallt airway unanimously strongly supports the institution of follow-
up care of a patient who has had a difficult airway. The Task Force
will make three recommendations. First, the difficulty should be doc-
umented in the medical record (including a description of the exact
difficulties that were encountered and the various airway management
techniques that were used). Second, the patient should be personally
informed of the airway difficulty that was encountered. The information
may include the presence of the difficult airway, the apparent reasons
for the difficulty, and the implications for future care. Finally, the
anesthesiologist should evaluate and follow the patient for potential
complications of the management of the difficult airway.

In my recent article, 1 I described what I consider to be the "passive
cough technique"; namely, tracheal extubation that is immediately fol-
lowed by a forceful elastic recoil of the lung. Tracheal extubation is
performed in the operating room, postanesthesia care unit, and the
intensive care unit. In the operating room, I basically use the same
technique as described by Garla and Skaredoff, except that I allow the
airway pressure to increase to 15–20 cmH2O prior to cuff deflation
and tracheal extubation. In this setting, only one pair of hands is re-
quired (one person, one task) because the "large sustained inflation"
that I refer to in my article 1 is simply achieved by closing the pop-off
valve. When extubation is to be accomplished in the postanesthesia
care unit and the intensive care unit, then one individual is required
give the patient a large sustained inflation using some sort of reservoir
bag, while another person simultaneously deflates the cuff and pulls
the endotracheal tube (two people, two simultaneous tasks). Given the
usual staffing of postanesthesia care units and intensive care units, per-
formance of the "passive cough" extubation technique in these envi-
ronments is simple to accomplish. We all agree that the passive cough
technique helps to clear the airway and vocal cords of secretions.

Goldman et al. make the point that anesthesiologists may be unfa-
familiar with and perhaps underestimate the Jackson anterior commissure
laryngoscope. This main point is valid, but their letter warrants several
comments. First, in the case that they describe, fiberoptic orotracheal
intubation would have been a good first choice. Second, adequate
anesthesia of the laryngeal surface of the epiglottis and suppression of
the gag reflex is sometimes difficult to obtain with just an oral topical