

CORRESPONDENCE

Anesthesiology

1998; 89:545

© 1998 American Society of Anesthesiologists, Inc.
Lippincott-Raven Publishers

Flexiguide Intubation Guide to Facilitate Airway Management with WuScope System

To the Editor:—We have used the WuScope (Ach Corporation, Fremont, CA) for tracheal intubation in 22 patients. Our experience is in keeping with those who have found it to be a reliable device for this purpose.¹ In all of our patients, the larynx was easily visualized with this bivalve, curved tubular laryngoscope that incorporates a nasopharyngoscope equipped with a high-power optical light source. In four patients, however, we had difficulty in directing the suction catheter that was recommended as a guide for insertion of the endotracheal tube into the trachea. In these patients, intubation was facilitated using a Flexiguide intubation guide (NCC Division, Mallinckrodt, Hook Road Argyle, NY) (Figure). The flexible tip of this device can be maneuvered by manipulating the thumb ring at its proximal end. Thus, it is easier to introduce into the larynx than is a regular suction catheter. The technique involves introduction of the WuScope loaded with the endotracheal tube and the Flexiguide into the oropharynx until the epiglottis and the vocal cords are brought into clear view. Then the Flexiguide is advanced into the larynx by appropriately adjusting the direction of its tip. WuScope and Flexiguide are operated with separate hands, thus circumventing any problems that may arise from the combined use of these two relatively large devices. We believe that our technique minimizes the occasional difficulty encountered when intubating with the WuScope.

Daniel O'Neill, M.D.

Chief Resident Anesthesiology

Levon M. Capan, M.D.

Associate Professor Clinical Anesthesia

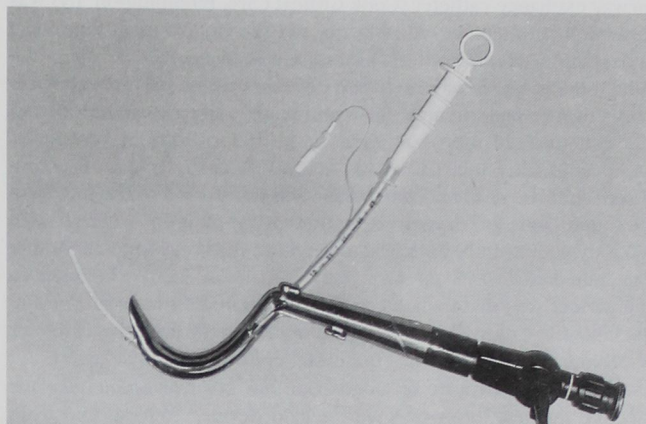


Fig. 1. WuScope system[®] incorporating an endotracheal tube placed over a Flexiguide[®] intubation guide.

Rajul Sheth, M.D.

Clinical Assistant Professor of Anesthesiology
Department of Anesthesiology
The New York University School of Medicine
New York, New York

Reference

1. Wu T-I, Chou H-C: A new laryngoscope: The combination intubating device. *ANESTHESIOLOGY* 1994; 81:1085-7

(Accepted for publication April 7, 1998.)

Anesthesiology

1998; 89:545-6

© 1998 American Society of Anesthesiologists, Inc.
Lippincott-Raven Publishers

Emergent Airway Management at a Remote Hospital Location in a Patient Wearing a Halo Traction Device

To the Editor:—Airway management of a patient in halo traction may be difficult. These difficulties may be compounded by additional challenges, including (1) the emergency need for airway management, e.g., cardiac arrest; (2) multiple previous laryngoscopies; or (3) patient anatomic features that indicate difficult tracheal intubation.

An 89-yr-old man with a medical history of hypertension and disseminated prostate cancer was admitted to the hospital for treatment of a posterior C2 fracture sustained in a fall. A halo device was placed the previous day without complication, and the patient was in a

telemetry unit, although in an unmonitored bed. At approximately 1:00 AM, the patient had generalized seizures followed by unresponsiveness. An electrocardiogram showed asystole. Chest compressions and bag-mask ventilation were instituted by the internal medicine team leading the resuscitation, and 5 mg epinephrine and 1 mg atropine were administered. Five attempts at direct laryngoscopy, using Macintosh-3 and Miller-2 blades, were unsuccessful. Ventilation by mask became more difficult in part because of gastric air distension, although the patient had an idioventricular rhythm. The Anesthesiol-