References


In Reply—We thank Patel et al.1 for their interest in our article describing the use of the cuffed oropharyngeal airway (COPA) in the management of the difficult airway and nasal fiberoptic intubation.

We agree that the COPA does not always provide hands-free airway support as shown in the recent article.2 However, the manual support required when using the COPA is not as extensive as with the endoscopic mask. For example, the first patient in our report1 required only a gentle chin lift with one finger. More importantly, as shown in our second case,1 the need for additional airway support can often be eliminated with the proper use of the white rubber strap (commercially supplied with the COPA) or a slight neck rotation to a side, or both.

The study Dr. Patel cited as evidence for the relative ineffectiveness of the COPA compared to the endoscopic mask in supporting ventilation3 is not applicable because the authors used muscle relaxants and compared the COPA with a face mask while using positive ventilation. However, the COPA, similar to the laryngeal mask airway, is designed predominantly for use during spontaneous respiration and NOT for paralyzed patients. Muscle relaxation, by reducing the tone of the upper airway muscles, presumably renders the pharyngeal seal by the COPA less effective.

We admit that the nasal tracheal intubation with the COPA in place requires somewhat complicated manipulations, as described in the letter, probably because the fibroscope passes around the lateral side of the cuff of the COPA. However, we found these technical difficulties relatively easy to overcome, as evidenced by the steep learning curve in our study.1 Moreover, we had very positive feedback from both resident and staff anesthesiologists. Residents may perform fiberoptic intubation at their own pace while the patient is asleep. For staff, maintaining an adequate airway and an optimal depth of anesthesia provided by the COPA enhances patient safety while teaching fiberoptic intubation. Therefore, we believe our technique facilitates the teaching and learning of fiberoptic intubation.

In conclusion, our case report suggests that (1) in cases in which difficult intubation is anticipated, the COPA permits spontaneous breathing and inhalation anesthesia while nasal fiberoptic intubation is being performed and (2) the presence of the COPA does not interfere with the passage of the fibroscope.

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