CORRESPONDENCE

adult respiratory distress syndrome. He was being ventilated with 100% oxygen and maintaining a saturation of 85%. The task was to
replace the 6.5-mm nasal ETT with a 8.5-mm oral tube. After the upper airway was topically anesthetized and the intravenous seda-
tion was administered, the WuScope, preloaded with the new ETT,
was inserted into the oropharynx and positioned anterior to the
nasal ETT. As the blade entered the vallecula, the triangular opening
between the anterior commissure of the vocal cords and the nasal
ETT was easily exposed. A suction catheter (18 French) was ad-
vanced out of the new ETT lumen and passed through this triangular
opening into the trachea. With the suction catheter securely held in
place by the operator firmly compressing the new ETT at its prox-
imal end, the nasal ETT was removed. The new ETT was then
advanced over the suction catheter into the trachea. The entire tube
exchange procedure was performed by one person, took only a few
minutes, and the actual conversion time was less than 10 s, with no
change in oxygen saturation.

The WuScope is a tubular laryngoscope with fiberoptic imaging.
The rigid blade allows exposure of the larynx. The tubular structure
overcomes soft tissue obstruction, creates an intubating space, and
protects fiberoptic lenses from secretions. Most importantly, there is minimal interruption of the patient’s ventilatory support, and the operator can visually ensure the new ETT a free passage through the glottis. The WuScope technique for tube exchange has worked well for us and should be considered by others as an alternative approach to this important and difficult problem.

Lastly, we would like to share with the readers some issues of importance. First, as with any of the previously reported tube exchange methods, previous expertise with the use of the WuScope is essential. In our institution, we have a combined experience of more than 1000 intubations with this device. Second, we find the use of muscle relaxants is often not necessary for tube exchange using the WuScope technique because glottic exposure can be achieved in the neutral position without jaw lifting or head extension. Before the procedure, we first thoroughly suction the patient’s upper airway, then trickle 10 ml lidocaine, 2 or 3%, into the pharynx to allow the glottic area to be anesthetized. Third, as with other techniques, care must be taken to ensure that the suction catheter is not inadvertently withdrawn as the original ETT is removed. Fourth, if one is concerned that the oxygen insufflation provided through the WuScope oxygen channel may be insufficient for a patient with severe adult respiratory distress syndrome, a tube exchanger, rather than a suction catheter, may be an alternative conduit for tube advancement and may provide the opportunity for jet ventilation if oxygen desaturation occurs or if the tube exchange requires additional time.
guide AW-04018, Arrow International, Inc., Reading, PA is now gently advanced through the cannula into the vein. In most instances, this guide wire is easily inserted, even into very small veins, and can be seen tracking inside the vein for some distance up the limb. The cannula is now advanced over the guide wire with full confidence that it will end up lying freely within the lumen of the vein and that it will provide a very reliable intravenous route.

This technique should be considered for all very small infants and especially for those in whom all the "good veins" have already been used, traumatized, or both. During the past month I have used this method in 11 infants, and it has been successful in every case. A former resident, now a practicing pediatric anesthesiologist, has also adopted this method, has proclaimed it to be most useful, and encouraged me to submit this report (R. Seal, personal communication, 1998).

David J. Steward, M.B., B.S., F.R.C.P.C.
Professor of Anesthesiology
University of Southern California
Director of Anesthesiology
Children’s Hospital Los Angeles
Los Angeles, California
DSTEWARD%SMTPGATE@CHLAIS.USC.EDU

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