content [(wet weight--dry weight)/wet weight×100%], lung MDA contents, SOD activity, lung permeability index (bronchoalveolar lavage fluid protein concentration/serum protein concentration), lung histamine concentration, and lung histology assay and MC counts (Table 1).

The major findings of our study were that MDA content was increased and SOD activity decreased remarkably in model group. Pretreatment with cromolyn sodium attenuated the upregulation of MDA content and the downregulation of SOD activity. The lung injury score was positively correlated with MDA content, whereas negatively correlated with SOD activity in the four studied groups. Lung water content and lung permeability index of model group were increased significantly compared with that of the sham-operated group. However, there was no significant difference in MC count and histamine concentration among the four groups. The results were different from that of Kasaka and colleagues, 7 but we propose that different animal models may produce different results, and this hypothesis need further investigation.

Our data provide evidence that cromolyn sodium demonstrates protective effects in vivo on IR-triggered lung injury in rats without a change in MC counts or histamine concentration. Downregulation of MDA content and upregulation of SOD activity may be an important mechanism of action. Further studies are necessary to measure tryptase level.

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The Glidescope® for tracheal intubation in patients with ankylosing spondylitis

Editor—After reading the article on use of Glidescope® for tracheal intubation in patients with ankylosing spondylitis (AS), 1 we had an opportunity of using this in a patient with AS with predicted difficult intubation on preoperative evaluation.

A 43-yr-old male patient (weight 40 kg and height 160 cm) with AS + rheumatoid arthritis was undergoing removal of infected hip prosthesis. His current preoperative airway assessment was: Mallampati classification III, thyromental distance 4 cm, inter-incisor gap 2 cm, and atlanto-occipital extension completely limited. We initially planned neuroaxial anaesthesia. Unfortunately, our attempts failed and the operation was cancelled. The next day, we prepared all the required equipment for difficult airway and intubation. In the operating theatre, heart rate, non-invasive blood pressure, and peripheral oxygen saturation were monitored. After an efficient preoxygenation, the patient received i.v. 1 µg kg⁻¹ of fentanyl and 2 mg kg⁻¹ of propofol. After full neuromuscular relaxation with 1.5 mg kg⁻¹ of suxamethonium, Macintosh (Heine, Germany) laryngoscope with a size 3 blade was used for initial direct laryngoscopy. Laryngeal view was grade IV (Cormack Lehan) and the glottic opening was not viewed. For the second attempt, a McCoy laryngoscope was used, but also failed. Then we attempted to use the Glidescope®. As the cervical spine was totally immobile, neither extension nor flexion of the neck was possible, using Glidescope® was difficult and we could hardly place it in the mouth. Although we could not obtain a better laryngoscopic view, we blindly inserted an orotracheal tube, but it was not in the correct place and was removed. Meanwhile, the patient had started to breathe spontaneously. Fibre-optic intubation was attempted, but failed as nasal route was not patent. The patient then received additional propofol for placing an alternative airway device. Initially, comitubé was placed, but peripheral oxygen saturation started to decline and this was replaced by an LMA Fastrack. The patient was ventilated with 50% oxygen–air mixture in approximately 1–1.5% sevoflurane and remifentanil infusion of 0.2 µg kg⁻¹ min⁻¹ was
added. Infected hip prothesis was removed in 30 min by surgeons.

Anaesthesia for patients with AS as neuraxial blocks may be difficult and general anaesthesia is then required.\textsuperscript{2} It has been reported that Glidescope\textsuperscript{®} improved better laryngeal view and provided better glottic exposure in patients with simulated difficult airway and in patients requiring general anaesthesia for elective surgery without difficult airway.\textsuperscript{3,4} In contrast, we were unable to intubate using the Glidescope\textsuperscript{®}. Lai and colleagues\textsuperscript{1} successfully performed nasotracheal intubation using the Glidescope\textsuperscript{®} in 8 of 11 difficult laryngoscopy patients with AS. As our patient’s nasal route was not patent, we cannot comment on this approach. In patients with severe AS, a difficult airway and insufficient nasal access still remain problematic.

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Evaluation of the LMA CTrach

Editor—The recent article of Liu and colleagues\textsuperscript{1} added valuable experience to the mechanisms involved in poor views using the new video-assisted ILMA CTrach. However, they did not address the need for a better-designed mask size for male adults, especially for obese and more than 170 cm height patients. In our experience of 15 consecutive adult patients [height 165 (sd 5)cm; 11F/4M] undergoing bariatric surgery [BMI 43.5 (6.5)], one patient had difficult ventilation and two patients required repositioning for optimal ventilation, and three had difficult intubation through the CTrach which was resolved by direct laryngoscopy. All these patients were male. In three patients, blind intubation was performed because of difficulties in visualizing the glottis besides proper handling. The positioning of the LMA was performed by two experienced anaesthetists, used the ILMA and applying all the manoeuvres necessary to accomplish a good positioning of the mask. Although the ability to ventilate anaesthetized patients through the CTrach has been successful in most studies, its rate of success in visualizing the laryngeal inlet and the appropriate length of the connector at the labial rim remain as problems. The small number of patients does not allow us to make any significant conclusion, but from a clinical point of view, we suggest a revision of the CTrach conformation\textsuperscript{2} to allow for anatomical variations in the ‘big adult’ is due.

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Editor—We thank Dr Cattano and his colleagues for their interest in our work. We understand their concerns about the need for a suitable CTrach mask for tall, obese male patients, although the need in our population is less pressing. We had, in fact, discussed such a requirement with the company after our earlier work. Our understanding is that they are working on a modified size 5 CTrach airway of suitable tube length and curvature specifically for such patients. We look forward to this development.

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