Table 1 Details of initial difficult tracheal intubation and those of face-to-face Video-Airtraq™- assisted tracheal re-intubation with the patients placed in the beach-chair/sitting position. Predictors: Number of difficult airway management predictors identified at the peroperative airway evaluation depicted from the following list: morbid obesity, sleep apnoea syndrome, Mallampati grade of 3 or 4, mouth aperture of <30 mm, thyromental distance of <70 mm, cervical perimeter measured at the level of thyroid cartilage of >45 cm in males and 40 cm in females, severe receded mandible, previous impossible tracheal intubation, severely fixed cervical spine; TID, tracheal intubation; ML, Macintosh laryngoscope; ES, Eschmann stylet; LMA-FT, LMA Fastrach™; C&L, Cormack and Lehane grade of laryngoscopy view; IDS, calculated intubation difficulty score; $S_{O2}$ L, lowest $S_{O2}$ during airway management; TID, tracheal intubation duration, extracted from anaesthesia records (initial difficult airway management) or calculated on video-recorded films as the time elapsed between distal blade of the Airtraq™ laryngoscope enters the oral cavity and the cuff of the tube is inflated in the trachea. *Conventional use of the Airtraq™ laryngoscope with direct top lens vision; 1conventional use of the Airtraq™ laryngoscope with the video-screen vision

### Use of the GlideScope in paediatric foreign body upper airway obstruction

Editor—Paediatric upper airway obstruction due to foreign bodies can be challenging to manage and distressing for the patient and family. A multidisciplinary team including anaesthetists, otolaryngologists, and paediatricians must be involved so as to ensure expedient retrieval of the object without compromising the airway. In some cases, direct laryngoscopy can be challenging due to the presence of a foreign body in the upper airway and all possible adjuncts should be available before attempting extirpation of the foreign body, including provision for a surgical airway.

Video laryngoscopy using the GlideScope (Verathon Inc., Bothell, WA, USA) provides real-time video images of the upper airway to aid intubation, which is particularly useful when managing difficult airway situations.

During one such situation of paediatric upper airway foreign body obstruction in our institution, the GlideScope facilitated safe extrication of the foreign body without jeopardizing the airway. The case was of a 7-yr-old male with no previous medical problems who was brought into the resuscitation room in the emergency department after suffering a respiratory arrest at home, after a choking episode. The history given by the parents did not suggest foreign body inhalation; however, X-ray imaging revealed a spherical foreign body in the upper airway. The child was immediately transferred to theatre with senior anaesthetic and otolaryngological teams present. Direct laryngoscopy was problematic due to the presence of a large marble lying on the top of the glottis, creating a ‘ball valve’ effect during respiration. The decision was made to utilize the GlideScope video laryngoscope, which enabled full visualization of the airway and obstructing foreign body (Fig. 1) and facilitated direct removal using Magill’s forceps.
laryngoscopy fails to provide an adequate view of the upper airway.

**Declaration of interest**

None declared.

L. Warner*
A. Daudia
Northwest Deanery, UK
E-mail: lauratod@doctors.org.uk

doi:10.1093/bja/aeu171

**Plasma fibrinogen measurement during cardiopulmonary bypass: a tool for early guidance of fibrinogen supplementation in cardiovascular surgery?**

Editor—We read with great interest the article regarding the time course of haemostatic effects of fibrinogen concentration in patients undergoing aortic surgery with cardiopulmonary bypass (CPB) by Solomon and colleagues.1 In Portugal, we have the benefit that fibrinogen concentrate (Haemocompletan P, CSL Behring) is licensed in acquired hypofibrinogenemia as in, for example, Germany,2 and we use it in cardiovascular surgery and other clinical settings—in fact, fibrinogen concentrate was first introduced in Portugal in 1978 (Fibrinogenio Humano). The information the authors provided is useful, and we believe further analysis of the coagulation test results obtained could be of clinical relevance. Although few data are available,3 4 it might be speculated that measuring fibrinogen levels during CPB could provide an estimation of fibrinogen deficit after CPB that could be used to guide early

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Fig 1 Picture of a marble in the supraglottis as seen with videolaryngoscopy using the GlideScope.