Letters to the Editor

The Airtraq to facilitate endotracheal tube exchange in a critically ill, difficult-to-intubate patient

To the Editor:

The difficulty of advancing the endotracheal tube (ETT) over a fiberoptic scope was recently reviewed [1,2]. A device that visualizes passage of the ETT over a fiberoptic scope/airway exchange catheter into the trachea may optimize the maneuver. Several devices visualize the glottis: the GlideScope (Saturn Biomedical Systems, Inc, Burnaby, BC, Canada), the McGrath video laryngoscope (LMA North America, San Diego, CA), the Karl Storz video laryngoscope (Karl Storz Endoscopy–America, Inc, Culver City, CA), and devices that visualize the glottis and facilitate intubation—the LMA C-Trach (LMA North America) and the Bullard laryngoscope (Circon ACMI, Stamford, CT). All of these devices may need assembly and may not be readily available in critical situations.

The Airtraq (King Systems, Noblesville, IN) is a new battery-operated, disposable, optical laryngoscope that provides a high-quality view of the glottis and allows intubation without alignment of the oral, pharyngeal, and tracheal axes. It was developed for management of the normal and difficult airway [3]. The Airtraq consists of two side-by-side channels: one accepts the ETT, whereas the other is the optical system. The Airtraq is an easy-to-use, intuitive device in both experienced and inexperienced hands [4,5].

We present the Airtraq to facilitate an ETT exchange in a difficult-to-intubate, critically ill obese patient (body mass index = 35). The intubated patient (with a history of difficult laryngoscopy and intubation) was transported to the operating room (OR) for an emergent abdominal surgery with a “defective” ETT pilot balloon. The patient was moved to the OR table and positioned for intubation. The stomach was suctioned and cricoid pressure applied. After rapid-sequence induction, a “soft tip” Cook airway exchange catheter (Cook, Bloomington, IN) was inserted and left in situ after removal of the defective ETT. The Airtraq, with a number 8 ETT mounted with its bevel down (anticlockwise rotation), were railroaded over the airway exchange catheter (Fig. 1). The Airtraq was advanced to visualize the airway exchange catheter penetrating the glottis. Then the ETT was advanced under direct visualization over the airway exchange catheter into the trachea. The glottis was edematous, and the ETT was inserted into the trachea without trauma while cricoid pressure was maintained.

Endotracheal tube exchange is a critical maneuver performed routinely outside the OR where the practitioner has limited expert and technical support. The Airtraq may optimize advancement of the ETT over an exchange catheter as it visualizes the limiting step of the maneuver, places the “beveled down” ETT in the immediate vicinity of the glottis, and then directs the ETT toward the glottis.

Other useful features of the Airtraq are the following: it is readily portable, there is no assembly needed, and it has a built-in antifogging system. The Airtraq ETT exchange technique may be useful in healthy and difficult-to-intubate

Fig. 1 The Airtraq (King Systems Corp., Noblesville, IN) with the mounted endotracheal tube (ETT) is railroaded over the airway exchange catheter placed in the trachea. This Seldinger technique will bring the Airtraq and the ETT in the immediate vicinity of the glottis.

☆ Dr Adrian A. Matioc receives royalties from King Systems Corp, Noblesville, IN, for the ergonomic face mask product.

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An incorrect—but previously correct—surgical side/site marking

To the Editor:
Side/site marking before a surgical procedure involving laterality is both important and required. Recently, New York State modified the marking criteria, which became effective on March 1, 2007. It includes the surgeon using his or her initials to mark the site with a permanent marker that remains visible after the surgical preparation. The physician marking the site must also participate in the time-out that is to be performed in the operating room. I report a case below in which this correct marking could have led to a wrong-side surgery error.

The patient was a 79-year-old man with peripheral vascular disease, who presented for angiography. The right femoral artery was to be accessed percutaneously to allow for examination of the left lower extremity. As required by New York State law, the surgeon correctly marked the right lower extremity with initials. The angiography was completed uneventfully. Two days later, the patient presented for revascularization of the left lower extremity by the same surgeon. On examination of the patient, a marking with the surgeon’s initials was present on the right lower extremity. If accepted as the current marking, this marking could have led to a wrong-side surgery. The surgeon correctly marked the left lower extremity with initials again and dated it. The surgery was performed on the correct extremity.

This case shows that it is important for the anesthesiologist to communicate with the surgeon and that a marking may be incorrect. It is important for the surgeon to know the patient well and not just rely on the marking. Perhaps a recommendation should be added to the state regulations that the marking be either washed off or invalidated by crossing it out once the surgery is completed.

To the Editor:
In this prospective study, the low-frequency (two-5 MHz) ultrasound probe, which is frequently used for focused abdominal sonographic assessment in emergencies, was evaluated in orthopedic trauma patients for use in examination and block of the sciatic nerve.

Thirty-two patients, admitted for emergencies involving tibial and/or ankle fractures, were randomized in a one-to-one ratio, stratified with regard to age, gender, and body mass index (BMI), and allocated to one of two groups for the study. The first group (n = 16; age, 69 ± 13 y; weight, 62 ± 15 kg; and BMI, 23 ± 16 kg/m²) underwent sciatic nerve block with ultrasound, whereas the second group (n = 16; age, 59 ± 18 y; weight, 68 ± 14 kg; and BMI, 22 ± 9 kg/m²) received neurostimulation with a conventional technique.

Patients in both groups first were placed semi-prone, with the affected limb uppermost. In the first group, the curved probe (SonoSite 180 Plus, 2-5MHz curved probe, Bothell,