Concerns about the Purported Safety of Elective Flexible Bronchoscopic-assisted Intubation

To the Editor—Heidegger et al.1 are to be congratulated for a well-performed study that validates the relative safety of their practice. The conclusions from their study, however, can be applied only narrowly. First, as they admit, it was conducted by individuals with extensive previous experience with the technique. Indeed, each had performed more than 200 previous bronchoscopic intubations. Therefore, the study addresses the safety of bronchoscopic-assisted intubation for those needing to maintain, rather than acquire, this skill. It does not serve to document the equivalent safety of this technique with direct laryngoscopy for those with limited previous experience. Second, the study was performed on the very population not requiring flexible bronchoscopic intubation—namely, those with normal airways. The study falls short of documenting the absence of vocal cord sequelae when performed in patients who may require this approach. Third, the authors have compared the vocal cord sequelae resulting from a nasally inserted 6-mm tube with an orally inserted 7- or 8-mm tube. Nasal tubes assume a more vertical passage through the larynx and exert less force on the posterior glottis.2 Likewise, smaller tubes probably exert less force on the vocal folds and arytenoid cartilages.3 Finally, their technique involved the induction of anesthesia absent neuromuscular blockers. The national guidelines referred to,4,5 insofar as they address fiberoptic technique and NMB, the two groups was achieved with different agents, the study group received a silicone ETT. Using an identical tube such as a polyanil chloride ETT, and the study group received a silicone ETT. Using an identical tube such as a 6.0-mm-ID silicone tube in both groups would seem like a logical choice. In addition, both the study and control groups could have been intubated nasally to establish a more reliable control.

Another concern is the selection of patients undergoing surgery to eye, ear, and salivary glands, which could affect subjective discomfort associated with VCS. The authors did design the study to compare with the trial of Mencke et al.,5 which used a silicone ETT for fiberoptic cases and polyvinyl profiles of these two agents clearly differ and could result in distraction of symptoms, especially in the study group.

3. Selection of identical endotracheal tubes (ETTs). The authors used a smaller ETT for the study group (6.0 mm ID) and a larger ETT for the control group (7.0 mm ID for females and 8.0 mm ID for males).

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(Accepted for publication January 30, 2008.)
chloride for direct laryngoscopy cases, and acknowledge that future study is needed to assess silicone tubes and VCS in oral direct laryngoscopy ETT placement. With respect to anesthetic agents and ETT assignment, the authors state that the goal was to compare two established techniques and not to solely compare NMB versus no NMB. However, this is in contrast to the stated goal of the study and even to the title of the article itself.

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References


(Accepted for publication January 30, 2008.)