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In Reply—We thank Patel et al. (1) for their interest in our article
descrying the use of the cuffed oropharyngeal airway (COPA) in the
management of the difficult airway and nasal fibrescopic intubation.

We agree that the COPA does not always provide hands-free airway
support as shown in the recent article (2). However, the manual support
required when using the COPA is not as extensive as with the endoscopic
mask. For example, the first patient in our report (1) required only a gentle
chin lift with one finger. More importantly, as shown in our second case,(1)
the need for additional airway support can often be eliminated with the
proper use of the white rubber strap (commercially supplied with the
COPA) or a slight neck rotation to a side, or both.

The study by Patel cited in our article for the relative ineffectiveness
of the COPA compared to the endoscopic mask in supporting ventilation
is not applicable because the authors used muscle relaxants and com-
pared the COPA with a face mask while using positive ventilation.
However, the COPA, similar to the laryngeal mask airway, is designed predomin-
antly for use during spontaneous respiration and NOT for paralyzed
patients. Muscle relaxation, by reducing the tone of the upper airway
muscles, presumably renders the pharyngeal seal by the COPA less effective.

We admit that the nasal tracheal intubation with the COPA in place
requires somewhat complicated manipulations, as described in the
letter, probably because the fibroscope passes around the lateral side of
the cuff of the COPA. However, we found these technical difficulties
relatively easy to overcome, as evidenced by the steep learning curve
in our study (1). Moreover, we had very positive feedback from both
resident and staff anesthesiologists. Residents may perform fiberoptic
intubation at their own pace while the patient is asleep. For staff,
keeping an adequate airway and an optimal depth of anesthesia
provided by the COPA enhances patient safety while teaching
fiberoptic intubation. Therefore, we believe our technique facilitates the
teaching and learning of fiberoptic intubation.

In conclusion, our case report suggests that (1) in cases in which
difficult intubation is anticipated, the COPA permits spontaneous
breathing and inhalation anesthesia while nasal fiberoptic intubation is
being performed and (2) the presence of the COPA does not interfere
with the passage of the fibroscope.

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