"difficult intubation" for a thoracotomy at another institution 1 yr previously. Room air oxygen saturation was 90%, which increased to 97% with a mask that partially fit the patient's mouth. An arterial catheter was inserted.

The induction plan was to use oral topical anesthesia with 10% lidocaine spray and to try awake laryngoscopy first, to avoid tracheotomy if possible. No intravenous sedation was given. During attempted laryngoscopy with the Macintosh and Miller blades, no pharyngeal structures except the base of the tongue could be identified. The Jackson laryngoscope (with a xenon light source) was introduced from the left side, displacing the tongue to the right, and clearly showed the vocal cords.

A 6-mm endotracheal tube (ETT) without the connector, with a stylet protruding 1 cm from its end, was introduced inside the scope. Once below the cords, the cuff was inflated, and while the stylet was being held, the scope was gently withdrawn while an assistant held the ETT deep in the pharynx. Dislodgement of the ETT was minimized because it was reasonably anchored by the inflated cuff and the stylet was in place. The procedure lasted less than 2 min without any major discomfort to the patient.

Fiberoptic oral intubation would have been the obvious second choice if direct laryngoscopy had failed. Retrograde wire intubation must be done blindly and might have induced bleeding in the nasopharynx in this patient. Either one of these techniques would have required more time than the Jackson laryngoscope to accomplish the intubation.

In addition, this tubular-type laryngoscope is more readily available in any operating room area as compared to an apparently improved version.5

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76:1059, 1992

J-wire Facilitates Translaryngeal Guided Intubation

To the Editor—In a description of retrograde techniques for tracheal intubation, Benuomof states, "the retrograde guide may be either a guidewire or any type of small-diameter luminal catheter that has a standard hub on the end of it." Several technical problems have prevented general use of this method: 1) the catheter does not pass easily through the vocal cords; 2) it is hard to see a luminal catheter in the oropharynx because of its transparency; and 3) it is difficult to pick up the catheter or a standard guidewire in the oropharynx without damaging the mucosa of the area.

To solve these problems, I have proposed the use of a J-wire, as used for central venous catheterization.2-4 The "J" shape of the wire allows easy entrance between the vocal cords without injury. With the "J" already in the oropharynx, a rotary motion around its axis produces an obvious and easily perceptible displacement within the oral cavity, which facilitates its location. At the same time, separating the tip of the wire from the mucosa makes it easier to pick it up by forceps, thereby decreasing the likelihood of mucosal trauma. I believe that this simple modification can increase the popularity of translaryngeal guided intubation among anesthesiologists.

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The Belscope for Management of the Difficult Airway

To the Editor—In response to Benuomof’s excellent article, I would like to make a few observations regarding the Belscope, an angled laryngoscope blade (fig. 1), particularly with respect to the three points of reservation discussed.

First, it has probably not been widely evaluated because it has either not been readily available (e.g., hidden away on a difficult intubation cart) or has not been purchased at all. I believe it should be more readily available for practice and training purposes, and therefore be

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Second, regarding the time commitment in acquiring skill with the angulated blade: it will attach to most standard laryngoscope handles and can therefore be readily available for practice in routine cases. Apart from the classical difficult case, the angulated blade is also very useful where awkward or poor dentition exists, because the proximal part remains well away from the upper teeth during both laryngoscopy and intubation.

Third, regarding the prism available for use with the BelScope and the problem of “fogging”: there are several ways to avoid this. The prism can be kept either alone, or ready-mounted on a spare blade in dry swabs or cotton wool in a known blanket-warming or similar cupboard, or an antisticking preparation can be used. Also available is a waxlike spectacle antisticking stick (which does require the prism to be polished prior to use).

I have not used the other new laryngoscope designs referred to in Benumof’s paper, but from my experience with the BelScope, I would certainly recommend it as having an easy “learning curve” and as a reliable and most useful instrument.

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In Reply—I completely agree with Kleinman that it is a very important responsibility of the anesthesiologist to administer appropriate follow-up care to a patient whose airway was difficult to manage. In fact, the American Society of Anesthesiologists (ASA) Task Force on the development of an ASA guideline for the management of the difficult airway unanimously strongly supports the institution of follow-up care of a patient who has had a difficult airway. The Task Force will make three recommendations. First, the difficulty should be documented in the medical record (including a description of the exact difficulties that were encountered and the various airway management techniques that were used). Second, the patient should be personally informed of the airway difficulty that was encountered. The information may include the presence of the difficult airway, the apparent reasons for the difficulty, and the implications for future care. Finally, the anesthesiologist should evaluate and follow the patient for potential complications of the management of the difficult airway.

In my recent article, I described what I consider to be the “passive cough technique”: namely, tracheal extubation that is immediately followed by a forceful elastic recoil of the lung. Tracheal extubation is performed in the operating room, postanesthesia care unit, and the intensive care unit. In the operating room, I basically use the same technique as described by Garla and Skaredoff, except that I allow the airway pressure to increase to 15–20 cmH₂O prior to cuff deflation and tracheal extubation. In this setting, only one pair of hands is required (one person, one task) because the “large sustained inflation” that I refer to in my article is simply achieved by closing the pop-off valve. When extubation is to be accomplished in the postanesthesia care unit and the intensive care unit, then one individual is required to give the patient a large sustained inflation using some sort of reservoir bag, while another person simultaneously deflates the cuff and pulls the endotracheal tube (two people, two simultaneous tasks). Given the usual staffing of postanesthesia care units and intensive care units, performance of the "passive cough" extubation technique in these environments is simple to accomplish. We all agree that the passive cough technique helps to clear the airway and vocal cords of secretions.

Goldman et al. make the point that anesthesiologists may be unfamiliar with and perhaps underestimate the Jackson anterior commissure laryngoscope. This main point is valid, but their letter warrants several comments. First, in the case that they describe, fiberoptic orotracheal intubation would have been a good first choice. Second, adequate anesthesia of the laryngeal surface of the epiglottis and suppression of the gag reflex is sometimes difficult to obtain with just an oral topical