

A technique to overcome inability to advance a tracheal tube over a fiberscope during nasotracheal intubation

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To the Editor:

Difficulty in advancing the tracheal tube over a flexible fiberscope (FOB) despite having the FOB in the trachea can be a frustrating experience. It happens because of deviation of the course of the tracheal tube from that of the FOB towards laryngeal structures [1, 2]. Multiple techniques have been reported in the literature to overcome this problem during nasotracheal fiberoptic intubation. Counterclockwise rotation of the tracheal tube is commonly used to overcome this problem. Other suggested ways are use of a tapered tracheal tube without bevel, and use of a Parker Flex-Tip tube [1, 2]. It has been found that the greater the gap between the FOB and the tracheal tube, the higher is the likelihood of facing this problem [1, 2]. Measures used to overcome this problem are to interpose a smaller diameter uncuffed tracheal tube or an Aintree intubating catheter or Cook airway exchange catheter between the tracheal tube and the fiberscope minimize the gap between the tracheal tube and the FOB [1, 2].

It is a well known fact that the tracheal tube usually aligns itself in front of the glottis when passed from the nose to the oropharynx. This forms the basis for the blind nasal intubation technique and for the 'tube-first approach' during nasal fiberoptic intubation [3, 4]. Based on a similar principle, we have successfully performed nasal fiberoptic guided intubation in two spontaneously breathing patients when faced with the difficulty in advancing the tracheal tube. In our technique, the fiberscope was withdrawn until its tip was outside the glottis. The tip of the fiberscope was

then made to project just outside the tip of the tracheal tube by first advancing the tracheal tube beyond the tip of the fiberscope and later withdrawing it until its tip disappeared from the visual field of the fiberscope. Attempts were then made to align the 'fiberscope-tracheal tube assembly' (FTA) in front of the glottis with the lever of the fiberscope in the neutral position. This can be achieved by adjusting the position of the pillow and the neck. When this is achieved, the FTA was advanced into the glottis when the vocal cords were maximally abducted. Unless the tip of the fiberscope is in neutral position at the time of advancing the FTA into the glottis, the procedure is likely to fail as the tip of the tracheal tube would go in a different direction than the tip of the fiberscope. When correctly done, this technique offers the unique advantage of being able to advance the tracheal tube under vision, thus minimizing contact of the FTA with the laryngeal structures and aiding in unhindered passage of the tracheal tube into the glottis. Advancing the tracheal tube over the fiberscope is a blind procedure in routine fiberoptic intubations and our technique helps to overcome this problem. We are confident that our technique adds another powerful technique to existing solutions for overcoming the peculiar problem of difficulty in advancing a tracheal tube over a fiberscope during nasal intubation.

Conflict of interest statement We do not have any conflicts of interest to declare.

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