

Flexible Bronchoscopy Still the Definitive Standard for Airway Management

To the Editor:

We read with great interest, but equal concern, the recent article by Rosenstock *et al.*¹ and the accompanying editorial by Fiadjoe and Litman.² Both publications confirm that flexible bronchoscopy “will still be required” and that anesthesiologists in “large number(s)... lack the commitment and desire to master fiberoptic intubation” and concluding that using a rigid videoscope represents a paradigm shift in anticipated difficult airway management is misguided. Indeed, in expert hands, not only was flexible bronchoscopy a reliable and efficient technique, equivalent in success rate and time to intubation to the McGrath video laryngoscope, but 7 of the 48 patients randomized to the McGrath video laryngoscope could not undergo the awake technique! The exclusion criteria (limited mouth opening and neck pathology prohibiting recurrent laryngeal nerve block *via* the transtracheal method) were also so restrictive that it is no surprise that the success rates of the two methods were equivalent. Head and neck pathology has already been associated with a high failure rate using video laryngoscopy.³ Perhaps any device chosen, including traditional Macintosh and Miller laryngoscopes, when this patient population was eliminated for investigation, would result in equivalent success. Given the fact that the success and time to perform an awake intubation was equivalent “in expert” hands, perhaps the recommendations should be that anesthesiologists and anesthesia trainees use flexible bronchoscopy more frequently to develop and maintain skills that require more practice and expertise rather than seek alternative and potentially limited devices that subjugate one’s required skillset. If we continue to compromise the development and maintenance of flexible bronchoscopic skills, future studies will inevitably demonstrate the superiority of the rigid devices in limited patient populations because of a lack of anesthesiologists who are skilled flexible bronchoscopists.

As clinicians and educators, we must squelch the desire to further encourage the steady erosion of advanced airway skills. Although we thank the authors for further demonstrating that video laryngoscopic methods have their role in managing patients with anticipated difficult airways, the need to perform awake flexible fiberoptic intubation is still an absolute vital skill that requires a renewed educational emphasis so that anesthesiologists can and will use this technique when indicated. Residency programs and airway workshops need to spend more time teaching the more difficult to master fiberoptic technique and less time teaching video laryngoscopy, which is easier to learn and maintain mastery of in the first place.

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(Accepted for publication October 10, 2012.)

Is Video Laryngoscopy Easier to Learn than Fiberoptic Intubation?

To the Editor:

In their editorial, Drs. Fiadjoe and Litman¹ refer to the protracted learning curve of fiberoptic intubation in contrast to video laryngoscopy. This difference applies primarily to clinicians experienced in direct laryngoscopy but not in fiberoptic intubation. Beginning residents may find fiberoptic intubation easier to learn than video laryngoscopy, achieving a higher success rate with less trauma sooner with fiberoptic intubation than direct laryngoscopy and subsequent video laryngoscopy.²

Training programs neglecting proficiency in fiberoptic intubation in favor of extensive experience with direct laryngoscopy may generate the graduates described by Drs. Fiadjoe and Litman. However, trainees graduating with proficiency in fiberoptic intubation and video laryngoscopy who continue to practice both make the comparison of academic interest only.

In summary, the observation by Drs. Fiadjoe and Litman regarding fiberoptics and video laryngoscopy may reflect differences among training programs rather than between the two techniques themselves.

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(Accepted for publication October 10, 2012.)