

requirements. The dose for each patient needs to be individualized to such variables as body weight, physical status, underlying pathologic condition, use of other drugs, and type of surgical procedure.

GEORGE GRIFFITHS
Group Product Director
Anesthesia Products
Janssen Pharmaceutica

40 Kingsbridge Road
Piscataway, New Jersey 08854

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Difficult Pediatric Intubation

To the Editor:—We would like to offer several comments on the recent report by Berthelsen *et al.*¹ The intubation technique described is based on the contention that available fiberoptic bronchoscopes are too large for use in over-the-scope intubation in infants. This is not correct. A scope of 2.7 mm external diameter is available from the Olympus Corporation (Olympus PF®, Type 27M) and it allows intubation with a 3.0 mm internal diameter endotracheal tube.

This report describes an infant in whom “a diagnosis of laryngomalacia was proposed.” It also states that “blind nasotracheal intubation with or without a stylet is the ordinary way of handling difficult pediatric intubations” but that their described technique “can be attempted even with minimal previous experience with fiberoptic laryngoscopies.” In our institution, management of infants with incompletely diagnosed upper airway pathology includes full examination of the nares, pharynx, larynx, and trachea under light sedation and topical anesthesia using a fiberoptic instrument. This can be followed by over-the-scope intubation. Because these procedures are not without complications, and diagnosis and evaluation require experience, they should be performed by or under the supervision of a skilled endoscopist.

We believe that the technique proposed by Berthelsen

et al. carries the risk of tracheal damage by the impaction of a too large endotracheal tube at the laryngeal opening. If a small bronchoscope is not available, we prefer to use the technique described by Stiles,² in which a soft catheterization wire is passed under direct vision through the biopsy port of a fiberoptic bronchoscope into the trachea, the scope removed, and an endotracheal tube passed over the wire.

RAYMOND B. LARAVUSO, M.D.
Associate Professor of Anesthesiology

WILLIAM H. PERLOFF, M.D., PH.D.
Assistant Professor of Anesthesiology and Pediatrics
Director, Pediatric Intensive Care Unit

University of Wisconsin
Madison, Wisconsin 53792

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In reply:—At the time this patient was treated, the only available fiberoptic instrument in our institution was the Olympus ENF-P® fiberlaryngoscope. The technique we developed proved to be simple, fast, and uncomplicated.

Today, we also have the Olympus BF 3C4® fiber-bronchoscope (3.7 mm OD, 60 cm) with an incorporated suction port. This instrument is very suitable for

the Seldinger-type approach to difficult endotracheal intubation first proposed by Stiles in 1974.¹ We are now using the two methods interchangeably and find them equally expedient.

In Denmark, the Olympus BF 3C4® is priced at \$10,000—approximately three times as much as the Olympus ENF-P® fiberlaryngoscope.