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Use of an 8-F Catheter to Assist with Bullard Laryngoscopy in Intubating the Trachea

To the Editor:—The Bullard laryngoscope, because of its rigid, anatomically shaped blade and fiberoptic light source, is used in patients in whom the trachea is difficult to intubate. Multiple techniques for intubating the trachea with a Bullard laryngoscope are described in the literature.¹⁻⁵ We find that the following technique is simpler, faster, and allows jet ventilation or insufflation of oxygen through a catheter, if required.

Our technique uses a 70-cm 8 F catheter and a two-part intubation catheter (Cook Critical Care, Bloomington, IN); fig. 1). These catheters have an easily removable Rapi-fit adapter (with luer lock and 15-mm connector), which allows jet ventilation or O₂ administration to the patient during the procedure. The tongue surface of a Bullard laryngoscope is well lubricated and introduced into the oral cavity in the midline position, while the head and neck remain in neutral position. The laryngoscope blade is passed over the tongue into the posterior pharynx and elevated against the dorsal surface of the tongue, allowing the blade to be positioned in front of the epiglottis and exposing the glottis. The 8 F catheter is passed through the channel, which exists next to the light source, and directed into the trachea under fiberoptic visualization (fig. 2A). Slight adjustment of the blade may be required to guide the catheter into the glottis. The Bullard laryngoscope is then carefully removed, while maintaining the catheter in the trachea.

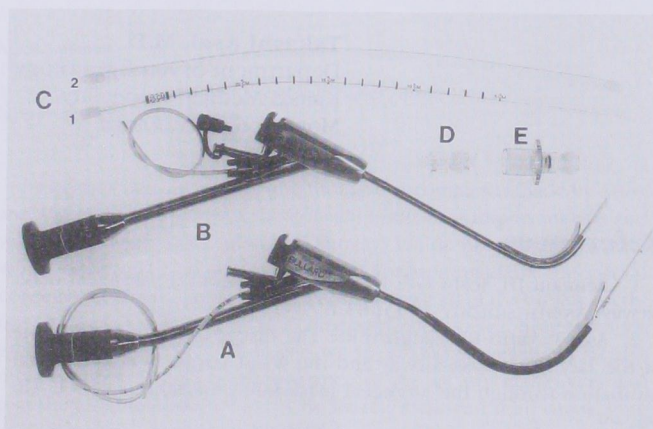


Fig. 1. (A) An adult Bullard laryngoscope with a 70-cm 8 F catheter in the channel. (B) A pediatric Bullard laryngoscope with a 50-cm 8 F catheter in the channel. (C) A two-part intubation catheter; 1. Distal part, 2. Proximal part (D) A luer lock Rapi-fit adapter. (E) A 15-mm Rapi-fit adapter.

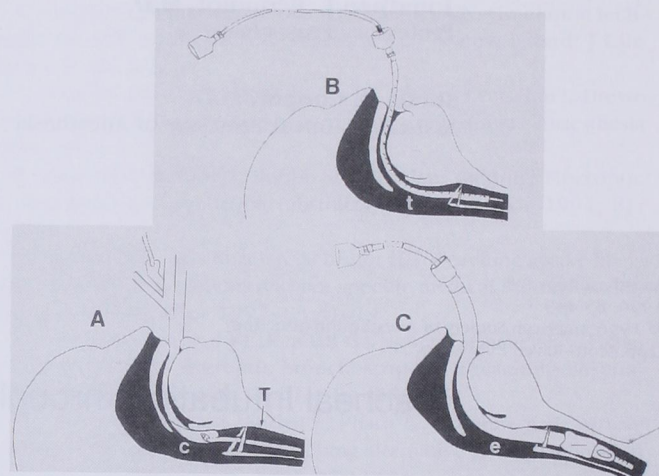


Fig. 2. (A) An 8 F 70-cm long catheter is passed through the channel of the adult Bullard laryngoscope and into the tracheal lumen (T). (B) The distal part of the two-part intubation catheter (t) is passed over the 8 F catheter and into the tracheal lumen. (C) The endotracheal tube (e) is threaded into the tracheal lumen.

The distal segment of the two-part intubation catheter is then passed carefully over the 8 F catheter into the trachea, and the second proximal segment is threaded onto the distal segment (fig. 2B). With the use of a two-part intubation catheter, kinking and impingement at the aryepiglottic fold by the 8 F catheter are less likely to occur than if an endotracheal tube were passed directly over the 8 F catheter. The endotracheal tube can then be passed over the two-part intubating catheter and into the trachea (fig. 2C). In pediatric patients, a 50-cm long 8 F catheter is used, and the endotracheal tube is directly inserted over the catheter without any difficulty.

There are several advantages to this technique: 1) the ability to maintain the head and neck in a neutral position and with much less manipulation of the airway than when a dedicated stylet is used; 2) the ease and rapidity of establishing access to the trachea with the 8 F catheter; 3) the ability to oxygenate and jet ventilate through the lumen of that catheter, if needed; 4) the passage of a two-part intubating catheter (for endotracheal tubes ≥ 7.0 mm) over the 8 F catheter is less likely to kink the 8 F catheter than an endotracheal tube is; and 5) the relatively atraumatic nature of these steps. We have had excellent success with this technique, and find that it takes approximately 30 s. We hope that others find it as useful.

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Practice Guidelines and Treatment of Patients with von Willebrand's Disease

To the Editor:—The Task Force on Blood Component Therapy of the American Society of Anesthesiologists is to be congratulated on the recent publication of "Practice Guidelines for Blood Component Therapy."¹ Unfortunately, recommendations concerning the use of cryoprecipitate in patients with von Willebrand's disease fail to incorporate recent evidence demonstrating the greater efficacy and safety of virally inactivated factor VIII concentrates in this setting.

Von Willebrand's disease represents the most common of the inherited bleeding disorders, with a prevalence as great as 1% of the population.² Subtypes of this disease are characterized by quantitative and/or qualitative abnormalities of von Willebrand factor, a plasma protein essential to platelet adhesion and the stabilization of factor VIII. Although DDAVP (desmopressin acetate) provides effective therapy in some patients with von Willebrand's disease, the response is unpredictable, frequently limited, and contraindicated in certain subtypes of the disease. Selection of the most appropriate therapy requires identification of the specific subtype of von Willebrand's disease present.

Administration of cryoprecipitate has been the traditional approach to management of bleeding in the patient with von Willebrand's disease unresponsive to DDAVP; however, more recent evidence demonstrates that select factor VIII concentrates provide a more efficacious and safe source for replacement of von Willebrand factor. Both the United Kingdom Regional Haemophilia Centre Directors and the Association of Hemophilia Clinic Directors of Canada have recommended the administration of virally inactivated factor VIII concentrates in preference to cryoprecipitate in the management of patients with von Willebrand's disease.^{3,4} In comparison with other factor VIII concentrates, Humate-P (Armour Pharmaceutical, Kanakakee, IL) contains the highest concentrations of von Willebrand

factor antigen and activity and has been recommended as the treatment of choice in managing patients with von Willebrand's disease unresponsive to DDAVP.^{5,6} The virally inactivated factor VIII concentrate Humate-P offers a safer, more efficacious approach than cryoprecipitate to management of the patient with von Willebrand's disease unresponsive to DDAVP. We suggest that the "ASA Practice Guidelines for Blood Component Therapy" be modified to incorporate recommendations concerning this recent advancement in the management of patients with von Willebrand's disease.

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