

Susan I. Phoenix, Mahesh Nirmalan, M.D., F.R.C.A., Ph.D.*
 *Manchester Royal Infirmary and Manchester Academic Health Sciences
 Centre, Manchester, United Kingdom. m.nirmalan@manchester.ac.uk

References

1. Brower RG, Lanke PN, MacIntyre N, Matthay MA, Morris A, Ancukiewicz M, Schoenfeld D, Thompson BT: Higher *versus* lower positive end-expiratory pressures in patients with the acute respiratory distress syndrome. *N Engl J Med* 2004; 351:327-36

2. Meade MO, Cook DJ, Guyatt GH, Slutsky AS, Arabi YM, Cooper DJ, Davies AR, Hand LE, Zhou Q, Thabane L, Austin P, Lapinsky S, Baxter A, Russell J, Skrobik Y, Ronco JJ, Stewart TE: Ventilation strategy using low tidal volumes, recruitment maneuvers, and high positive end-expiratory pressure for acute lung injury and acute respiratory distress syndrome: A randomized controlled trial. *JAMA* 2008; 299:637-45

3. Mercat A, Richard JC, Vielle B, Jaber S, Osman D, Diehl JL, Lefrant JY, Prat G, Richecoeur J, Nieszkowska A, Gervais C, Baudot J, Bouadma L, Brochard L: Positive end-expiratory pressure setting in adults with acute lung injury and acute respiratory distress syndrome: A randomized controlled trial. *JAMA* 2008; 299:646-55

4. Gattinoni L, Caironi P: Refining ventilatory treatment for acute lung injury and acute respiratory distress syndrome. *JAMA* 2008; 299:691-3

5. Phoenix SI, Paravastu S, Columb M, Vincent JL, Nirmalan M: Does a higher positive end expiratory pressure decrease mortality in acute respiratory distress syndrome? A systematic review and meta-analysis. *ANESTHESIOLOGY* 2009; 110:1098-105

6. Buchman TG: Physiologic stability and physiologic state. *J Trauma* 1996; 41:599-605

7. Rixen D, Siegel JH, Friedman HP: "Sepsis/SIRS," physiologic classification, severity stratification, relation to cytokine elaboration and outcome prediction in posttrauma critical illness. *J Trauma* 1996; 41:581-98

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Is It Time for a Glidescope Letter?

To the Editor:—I am the Vice-President of a large anesthesia practice based in Massachusetts. Our group provides services to a number of community hospitals, surgery centers, and an academic medical center. During the past 3 yr, our practice has acquired a number of Glidescopes (Verathon Medical, Bothell, WA), and we are using them with increasing frequency. It is now common for the Glidescope to be used as the first-attempt intubation device in patients who clinically present as a potential difficult airway. This is very much the case for patients undergoing bariatric surgery. A number of studies have shown that the Glidescope and other video airway devices, such as the Airway Scope (Pentax, Tokyo, Japan) and the Airtraq (King Systems, Noblesville, IN), have a higher successful intubation rate than that of direct laryngoscopy,¹⁻³ so our approach is founded on the principle that securing the airway in the shortest time, with minimal instrumentation, is in the best interest of the patient and represents good clinical care. In addition, there are also occasions when the Glidescope may be used as the first-line airway instrument for teaching purposes in both easy and difficult airways. This practice, though, is making me increasingly uncomfortable because of the implications for those patients in whom no attempt has been made at conventional laryngoscopy who may present for surgery, possibly emergent, at another institution that does not have a Glidescope. We are currently not telling all of our patients whether a Glidescope was used unless it was in the context of a failed

conventional laryngoscopy. These patients could present to other facilities and may indeed seem to be a potentially difficult intubation, only to have the anesthesiologist falsely reassured by a report of a prior "uneventful" anesthetic. The question, therefore, is should all patients in whom a Glidescope is used be given a letter indicating such, regardless of circumstance, and/or should all patients have one attempt made at conventional laryngoscopy, before elective Glidescope use, to document the airway classification for future reference?

I think this is an increasingly important clinical issue, with definite patient safety implications, and I would like to bring it to the attention of your readers for further contemplation and discussion.

Glynn D. Stanley, M.B., Ch.B., F.R.C.A. North Shore Medical Center, Salem, Massachusetts, and Anaesthesia Associates of Massachusetts, Westwood, Massachusetts. gdstanley@comcast.net

References

1. Nouruzi-Sedeh P, Schumann M, Groeben H: Laryngoscopy *via* Macintosh blade *versus* Glidescope: Success rate and time for endotracheal intubation in untrained medical personnel. *ANESTHESIOLOGY* 2009; 110:32-7

2. Maharaj CH, Costello JF, Harte BH, Laffey JG: Evaluation of the Airtraq and Macintosh laryngoscopes in patients at increased risk for difficult tracheal intubation. *Anaesthesia* 2008; 63:182-8

3. Asai T, Liu EH, Matsumoto S, Hirabayashi Y, Seo N, Suzuki A, Toi T, Yasumoto K, Okuda Y: Use of the Pentax-AWS in 293 patients with difficult airways. *ANESTHESIOLOGY* 2009; 110:898-904

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