I also had to take another factor into consideration—pulmonary aspiration. Airway reflexes are necessary to minimize aspiration, and to expel out aspirated materials from the airway, if aspirated. Therefore, while inhibition of the airway reflexes (by topical anaesthesia, sedation, or both) would reduce the stress to awake patients, it also increases the risk of aspiration. All three patients reported were at high risk of aspiration, and thus I applied topical anaesthesia only to the nasal cavities.

When it is unsuitable to give topical anaesthesia to the airway or unsuitable to give sedatives (like in these cases), one should find the least stressful and reliable method to achieve tracheal intubation. Insertion of the Airway Scope does not require extension of the head and does not distort the anatomical structures as much as the Macintosh laryngoscope does, and thus insertion should be less stressful. All three patients tolerated insertion of the Airway Scope and no marked straining was observed.

The Eschmann’s tube exchange catheter (gum elastic bougie) is designed to insert into the trachea by adjusting direction of its angulated tip. Therefore, the claim that inappropriate bending of the distal portion is unfavourable for insertion into the trachea is unwarranted.

As Dr Xue and colleagues point out, a fibreoptic bronchoscope may be used to guide the tube into the trachea. I did not use this, because at least two anaesthetists would be required. In contrast, the use of the bougie requires only one person, and is simpler.

While a recent letter states that the blade of the Airway Scope is frequently too short to reach the epiglottis, none of the major formal studies reports this problem. For example, in a study of 293 patients with predicted or known difficult tracheal intubation using the Macintosh laryngoscope, tracheal intubation using the Airway Scope was successful in 290 patients, and in none of the patients was it necessary to be aided by a fibreoptic bronchoscope, or did the blade of the Airway Scope fail to reach the epiglottis. At an early stage of using the Airway Scope, I experienced difficulty in reaching the blade tip to the epiglottis when the patient’s head and neck were placed to the sniffing position. The shape of the Airway Scope blade is designed based on the curve of the oropharyngeal cavity, with the head and neck in the neutral position. Therefore, it may be that the blade did not reach the epiglottis in the correspondence letter, because the patient’s head and neck were not properly placed to the neutral position.

As Dr Xue and colleagues indicate, none of the devices and manoeuvres is perfect, and thus we should continue to devise a method of least-stressful awake tracheal intubation in patients who are at high risk of pulmonary aspiration and whose airway is difficult to manage.

Conflict of interest
T.A. has received an honorarium from the manufacturer for giving lectures, but has not received any payment for research or evaluation of the Pentax-AWS or any other equipment from other companies.

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Paediatric Airtraq for adult nasal intubation in anaesthetized patients

Editor—We read with interest the report of the successful use of the Pentax-Airway Scope (AWS) videolaryngoscope (Hoya Co., Tokyo, Japan) for awake nasal intubation in patients with unstable necks. In the three cases described, the technique appears to have provided a swift and well-tolerated solution to three predictably difficult airway scenarios. A variety of optical devices have been developed in recent years to facilitate tracheal intubation. These include the Airtraq (Prodel Ltd, Vizcaya, Spain) and the Glidescope (Verathon Medical, Bothell, WA, USA), and the Pentax-AWS.

There is a growing body of evidence supporting their use in the management of patients with predicted and
Editor—I thank Drs Morris and Rangasami for their reporting an interesting use of a paediatric Airtraq. It seems reasonable to use a paediatric size to obtain enough space to insert Magill forceps and adjust the direction of the tube tip. For the Airway Scope (Pentax-AWS), I have found that there is no difficulty in inserting Magill forceps to drive the tube into the trachea. I believe that the manufacturer of Airway Scope is planning to produce smaller blades. Therefore, it would be informative to carry out formal studies assessing the method described by Drs Morris and Rangasami, and comparing the efficacies of their method between the Airtraq and Airway Scope.

Conflict of interest
T.A. has received an honorarium from the manufacturer for giving lectures, but has not received any payment for research or evaluation of the Pentax-AWS or any other equipment from other companies.

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Appropriate timing of administration of magnesium during spinal anaesthesia

Editor—I read with interest the article written by Hwang and colleagues1 regarding i.v. infusion of magnesium sulphate during spinal anaesthesia to improve postoperative analgesia. I have a few concerns regarding the timing of administration of magnesium for analgesia in patients having spinal anaesthesia for hip surgery.

First, spinal anaesthesia in elderly patients has the potential to cause a significant decrease in arterial pressure and this group of patients often have multiple medical problems. In these patients, prolonged and severe hypotension carries the risk of significant morbidity and mortality. The authors administered the bolus of magnesium immediately after spinal anaesthesia and started the infusion as well. I wonder about the safety of this situation considering the evidence supporting the arterial pressure-lowering properties of magnesium.2–3

Secondly, I have concerns about the interaction of magnesium with neuromuscular blocking agents and tendency to prolong the duration of action.4–5 Again according to the study, the authors administered the magnesium before confirming the success of spinal anaesthesia. In case spinal anaesthesia has failed, these patients would have had general anaesthesia with neuromuscular blocking agent. In this situation, there is a chance of prolonged neuromuscular block which is potentially harmful.

These concerns mean that I would be reluctant to administer magnesium immediately after performing spinal anaesthesia. It would be safer to give magnesium towards the end of the case as it would allow maximizing the analgesic properties without compromising the safety of the patients.

Conflict of interest
None declared.

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