

CR#40

Combined use of an Airtraq optical laryngoscope, Airtraq video camera, Airtraq wireless monitor, and a fiberoptic bronchoscope after failed tracheal intubation

Can J Anesth/J Can Anesth (2011)

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A 48-yr-old 150-kg male with morbid obesity (body mass index: 52 kg m⁻²) and obstructive sleep apnea syndrome was scheduled for a total thyroidectomy.

Preoperative airway assessment included a Mallampati grade 3, an upper lip bite test² class II, macroglossia, a thick neck, and a large left cervical mass that compressed and displaced laryngeal structures and the upper tracheal lumen.

The Airtraq was inserted without increasing sedation or administering extra topical analgesia. Guided by bubbling secretions during spontaneous ventilation, this step allowed partial visualization of the glottis in the upper right corner of the viewfinder.

Additional maneuvers were ineffective in optimizing visualization and centring the glottis in the middle of the viewfinder, hence, intubation was deemed impossible. Without removing the Airtraq, a FOB was inserted through the size 7.0 ETT mounted in the guiding channel. By viewing the FOB tip in the vicinity of the glottis through the AVC in the AWM, rotating the body of the FOB, and manipulating the tip control lever, the FOB was inserted into the patient's trachea and the ETT was advanced over the FOB. The procedure was carried out uneventfully.