

CR#14

Use of the Airtraq® with a fiberoptic bronchoscope in a difficult intubation outside the operating room

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A comatose 60-yr-old male, with extensive radiation therapy to the neck, required urgent tracheal intubation for respiratory failure (pneumonia). Airway examination revealed hardened neck structures, a limited mouth opening, a fixed mandible, the neck in flexion, and a reduced thyromental distance. **Two successful FOB attempts, were followed by the inability to slide either an 8.0-mm or a 7.0-mm endotracheal tube past the oropharynx.**

Using the rotational insertion technique, a small Airtraq®, loaded with a 7.5-mm ETT, was passed through the limited mouth opening. The glottis was fully visualized (“Cormack and Lehane grade 1 view”) in the left upper corner of the viewfinder. However, the hardened pharyngeal tissue did not allow any Airtraq® maneuvering of the glottis to the centre of the viewfinder for an optimal intubation attempt. Similarly, exterior laryngeal manipulation was ineffective.

With the Airtraq® in situ, the pediatric FOB was advanced through the ETT. The vocal cords were easily identified, and the ETT was advanced under direct visualization