Videolaryngoscopes are being used with increasing frequency in patients with known or anticipated difficult airway [1]. While they usually provide excellent glottic visualization, directing an endotracheal tube through the vocal cords can be challenging [2]. Additionally, airway trauma has been reported with the Glidescope rigid stylet [3-5]. A recent report described the use of a fiberoptic bronchoscope as a stylet during endotracheal intubation of a patient with a difficult airway while the glottis was visualized through the Glidescope videolaryngoscope [6]. After reading that report, we have used this technique multiple times with both the Glidescope and the Airtraq laryngoscope and have found that a fiberoptic bronchoscope functions as the ideal maneuverable stylet during videolaryngoscopy. The softness of the tip of the fiberoptic bronchoscope minimizes its potential for causing trauma, while the flexibility of its tip facilitates the negotiation of acute angles that other stylets may fail to negotiate.

An obvious limitation of this approach is the fact that fiberoptic bronchoscopes are expensive to purchase and to maintain. Using them as stylets would also limit their availability for other clinical use. Recently, we have arranged with our anesthesia technical assistants to set aside broken and decommissioned fiberoptic bronchoscopes for use as stylets instead of discarding them. This approach also has obvious limitations.

We, therefore, believe that there is a need for a new stylet designed like a fiberoptic bronchoscope without the fiberoptic bundles. The softness, flexibility, and maneuverability of such a stylet would facilitate the intubation of a difficult to reach larynx during videolaryngoscopy. A stylet built with such a design for such a specific use would be a useful tool for difficult airway management.

References