Reply to "Comparing Shikani Optical Stylet and Macintosh Laryngoscope for Orotracheal Intubation"

Mao Xu[1], Xiao-Xi Li[2], Xiang-Yang Guo[1], Jun Wang[1]

[1]Department of Anesthesiology, Peking University Third Hospital, Beijing 100191, China
[2]Department of Anesthesiology, Key Laboratory of Carcinogenesis and Translational Research (Ministry of Education), Peking University Cancer Hospital and Institute, Beijing 100142, China

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To the Editor: We thank Dr. Wang, *et al*.[1] for the comments in our article. With regard to the first comment point, we agreed with them that Cormack-Lehane grades 3–4 with Macintosh laryngoscope should be defined as difficult laryngoscopy. The definition of difficult airway in our paper should be difficult laryngoscopy, not difficult airway.[1] The laryngeal classification (Macintosh 3–4 blade) used in our study was defined according to the method of Cormack and Lehane,[2,3] in which the initial view should be performed without the application of external laryngeal pressure. We admitted that external laryngeal pressure might be used in clinical practice during laryngoscopy with Macintosh laryngoscope. The objective of our study was to investigate whether Shikani Optical Stylet is beneficial for the specific cervical spondylosis patients. As we all known that any external pressure on the neck might have potential detrimental effect on the cervical disease *per se*, whether external pressure used or not was crucial to make an objective conclusion in this specific group of patients. Furthermore, it was difficult to quantify the impact of strength of external pressure on laryngoscopy when we compared which device was better.

As for the second comment point, we already noticed that the sample size in our study was small. In our discussion part, we stressed the limitation of our preliminary study. In fact, it was very difficult to obtain a definite statistical conclusion in the difficult intubation subgroups. So far, the related literatures investigating optimal intubation devices for patients with cervical spondylosis were scarce. We expected more forthcoming studies on that issue in the future.

The third commnet point was the postoperative pain management. Our hospital had acute pain service and standard postoperative pain management protocol for cervical spondylosis patients. The protocol consisted of regular incisional infiltration with 0.25% ropivacaine after closing the incision and parecoxib 40 mg bid in the first 48 h following surgery. The pain management was comparable between two groups. Many previous studies showed that sore throat was one of the typical side effects of endotracheal intubation, which may have a powerful influence on the selection of different devices.[4]

We agreed with the fourth comment point – only the adjuncts used for intubations with two devices are valid variables for performance comparison. The required assistance in Table 3 of our study[1] referred to external laryngeal pressure. We explained this in discussion part of our study in detail. As we mentioned above, any external pressure on the neck with different types of cervical spondylosis might have potential detrimental effect on the cervical disease *per se*. We thought the less manipulation on the neck during the laryngoscopy and intubation, the safer for patients. Based on the fact that external laryngeal pressure was applied in all patients in the Macintosh laryngoscope group while only one patient in the Shikani Optical Stylet group, we thought that Shikani Optical Stylet was much more suitable for the airway management in patients with cervical spondylosis.

We hope above explanation could clarify the findings of our study.

References

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Address for correspondence: Prof. Jun Wang, Department of Anesthesiology, Peking University Third Hospital, No. 49 North Garden Street, Haidian District, Beijing 100191, China
E-Mail: luckyoldhorse@sina.com