

## Videolaryngoscope-assisted nasotracheal intubation: Another option!

Madam,

We read with interest the article on Truview PCD-video laryngoscope (VL) aided nasotracheal intubation (NTI) in cases series of orofacial malignancy with limited mouth opening by Patil *et al.*<sup>[1]</sup> We appreciate their use of Truview PCD VL for NTI in orofacial malignancy.

Despite the recent advances in airway management, NTI in oral and maxillofacial surgeries remains challenging. Submandibular stiffness, decreased mouth opening, and associated deformities of facial structures limit the available choices for airway management.<sup>[2]</sup> Traditionally, NTI was done blindly, with the assistance of conventional laryngoscope or through fiberoptic bronchoscope. All these have their own problems as mentioned by the author.<sup>[2]</sup> VL (Truview, Glidescope, etc.) have been recently described for NTI.<sup>[1,3]</sup> However, a good glottic view with VL does not guarantee an easy intubation.



**Figure 1:** The cuff inflation guides the endotracheal tube into glottis

These patients may have a large mass or raw area which may be traumatized with the use of equipments such as Magill's forceps and bougie (used by author).<sup>[2]</sup> We have done more than 30 Glidescope-assisted NTI in such patients with cuff inflation technique. We inflate the cuff of endotracheal tube with 15–20 mL of air as soon as it crosses the nasopharynx to guide its tip toward glottis [Figure 1].<sup>[3,4]</sup> We could intubate all our patients in a single attempt (even with 1.6 cm mouth opening) and believe that use of cuff inflation can be a good adjunct to VL for NTI in patients with orofacial malignancy.<sup>[3]</sup> The only limitation of NTI with VL is that mouth opening of the patient should be at least 1.5 cm (but definitely less than conventional laryngoscopy) for insertion of VL blade.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

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<b>Quick Response Code:</b>	<b>Website:</b> www.joacp.org
	<b>DOI:</b> 10.4103/joacp.JOACP_183_16

**How to cite this article:** Gupta N, Gupta A. Videolaryngoscope-assisted nasotracheal intubation: Another option!. *J Anaesthesiol Clin Pharmacol* 2018;34:554-5.

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