Pediatric Anesthesia

Quick and safe intubation by visualized passage of the tube-armed Bonfils fiberscope into the trachea

Sir — We appreciate the interest of Dr Liu *et al.* of our comparison of the intubation with fiberoptic intubation (FOI) or the Bonfils fiberscope (BF) of children with a difficult airway (1) and we will address each point in turn.

Children with known (documented) difficult and expected difficult tracheal intubation (restricted mouth opening) were included as were children with an unanticipated difficult direct laryngoscopy. This is clearly described within the 'methods' as well as 'results' section. Difficult direct laryngoscopy was confirmed in all patients described in this study.

Dr Liu *et al.* (2) state that '... it is impossible to advance the Bonfils into the middle of the trachea' and imply a greater risk to the patient if introduced past the vocal cords. This contradicts the initial description of the developer of the BF (3,4) and ignores decades of successful experience with it (5). Dr Liu's description of the intubation with the BF negates one of the main benefits of this device. Others describe the BF intubation technique recently as follows (5): 'The scope is then carefully guided through the glottic aperture, until tracheal rings can be identified.' It is precisely the visualization of the passage of the tube that enables a delicate navigation of the tube over the vulnerable glottis and subglottis. This feature is one of the most important advantages of the BF particularly in the care of children due to the threat of harming the narrow subglottis structures with blind intubation in situations of difficult airways (6). This technique was extensively described in the discussion.

Dr Liu *et al.* question the reason for the longer time for FOI. As described, '... the tip of the fiberscope needs to be placed into the trachea before the tube can be positioned there. ... The passing of the tube through the larynx is the most critical moment for potential failure and laryngeal injury ...'. This maneuver requires time. In comparison, the BF carries the tracheal tube during its placement into the middle of the trachea under continuous visualization. This requires less time than FOI.

Finally, the authors regret that no subgroup analysis was possible. We strongly agree with them and would have liked to recruit more patients. However, as stated (1) '... it is evident that the number of children with a difficult airway is low even in a large pediatric hospital ...'.

Ethics

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Disclosures

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