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Use of the video laryngoscopy in intensive care units

Uso de la videolaringoscopia en las unidades de cuidados intensivos

Dear Editor,

We have carefully read the interesting study by Dey et al.[1] comparing the use of the C-MAC video laryngoscope versus the Macintosh laryngoscope. We congratulate the authors for this. Several appreciations may be of interest.

In the methodological aspect, the absence of registration of the airway characteristics (for example, use of the MACOCHA scale) is a significant bias as the authors indicated since it does not guarantee the comparability of both groups. Moreover, the critically ill patient is characterized by a limited physiologic reserve, so the variable ''time'' as well as the success rate of each device, has a significant clinical impact.[2] In other words, success is not enough. It must be obtained in the shortest time; otherwise, it may increase morbidity and mortality secondary to hypoxia.[3] It is recommended in clinical practice to reduce the number of attempts to three as well as the instrumentalization time to avoid progression to a ''cannot intubate cannot oxygenate'' situation and to opt for alternative methods or devices in the event of a failed primary attempt.[4] The authors do not specify the local algorithm followed when failed intubation was declared, which is important. The study determined that the C-MAC required significantly more times a stylet to perform tracheal intubation. It is necessary to remember that there are several case reports of the upper airway injury secondary to its use as an adjuvant.

Currently, the routine use of video laryngoscopy[5] is defended in order to perform atraumatic tracheal intubations in the shortest time, although it is important to take care of two aspects; the experience and the type of device selected according to the context; otherwise, the results may differ from those expected.[5] Thus, video laryngoscopes with Macintosh blade such as C-MAC (Karl Storz, Tuttlingen, Germany) or McGrath MAC (Aircraft Medical, Edinburgh, United Kingdom) allow both direct and indirect laryngoscopy, making them the most appropriate for routine use, while those with a hyperangulated blade with or without a guide channel are reserved to treat the difficult airway as first choice or as a rescue device.[5] There are many reasons that justify the use of a video laryngoscope as a primary device[5]; they allow direct and indirect laryngoscopy in the case of those who have a Macintosh blade as previously exposed, reduce the incidence of an unanticipated difficult airway, optimize training by allowing instructions from a more experienced operator, maximize coordination of the team, allow the recording of the procedure, reduce the possibility of cross-infection when using disposable material and allow a greater distance from the operator with the airway of the patient.[6]

There are limited number of clinical trials on video laryngoscopy in critically ill patients. Similar multicenter studies are necessary to obtain more evidence in this setting.

Conflicts of interest

The authors declare no conflicts of interests.

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