

the advantages of improved gas exchange⁴ and reduced work of breathing.⁵ This combination may be of particular value in moderately obese, sleep apnoeic patients undergoing ENT procedures.

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Airway anaesthesia during fiberoptic endoscopy

To the Editor:

Fiberoptic intubation in conscious, sedated patients is not associated with significant haemodynamic alterations if adequate topical anaesthesia is employed. In the emergency setting, the use of translaryngeal and superior laryngeal blocks is generally contraindicated when the risk of aspiration of gastric contents is high. However, under most circumstances, adequate conditions for intubation can safely be established by restrained application of local anaesthetic (typically lidocaine 2–4%) directly on the pharyngeal/laryngeal mucosa, and vocal cords, *via* the working channel of the endoscope. Unfortunately, use of the operating channel for this purpose makes coincident suction of blood, mucus or secretions away from the endoscope tip more difficult. We have found that a standard 20 g epidural catheter can readily be threaded down the operating channel of the bronchoscope, to protrude 1–2 mm at the distal end and leaving a coil of 5–10 cm

at the control end; (threading is most easily effected by passing the catheter from the distal tip up to the operating controls, rather than vice versa). The presence of the catheter does not interfere with either retrograde suctioning, or antegrade oxygen flow, yet it facilitates measured application of topical anaesthetic from a syringe connected to the catheter via a standard epidural compression connection. The lone operator can readily inject local anaesthetic and apply intermittent suction (or continuous oxygen) without the confusion of multiple valves and stop-cocks, and without compromising the flexibility or utility of the flexible fiberoptic bronchoscope.

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Paradoxical vocal cord motion

To the Editor:

We were very interested to read the clinical report by Drs. Arndt and Voth on paradoxical vocal cord motion masquerading as pulmonary dysfunction in the recovery room.¹ As the authors point out, paradoxical vocal cord motion has been a great “masquerader” which has led not only to difficulties in diagnosis, but also to related errors in therapy.

For readers interested in the topic, the original description of this phenomenon in the anaesthesia literature, can be found in a previous volume of the *Canadian Journal of Anaesthesia*.²

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REPLY

Dr. Voth and I are also very interested in Dr. Tousignant's previous report on a functional stridor. We feel that these types of reports are very important in that it allows the anaesthetist to have some insight into the clinical aetiologies of postoperative stridor. Many times clinicians will intubate the trachea in patients with postoperative stridor in almost a reflex manner. These reports allow clinicians to have a differential diagnosis