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Reply:

We thank Dr. Dupanovic for his interest in our study. As mentioned in our manuscript,¹ we chose the two stylet angles to be studied based on the most common angulations used by anesthesiologists in our local practice. The distal 60° angulation used at our centre and in the study was heavily influenced by an expert in airway management who described using a stylet shape that closely approximates the shape of the GlideScope® blade.² We believe that these are clinically relevant stylet angulations that merit comparison to each other. Based on our study and the observations of others,³ we believe that the initial stylet configuration for orotracheal intubation using the GlideScope® should be 90°, as described in detail in our study.

We agree that experience is a potential confounding variable in airway instrumentation research, and this emphasizes the importance of randomization to equally distribute potential known or unknown confounders among the groups being studied. Since analyzing times to intubation (TTI) based on experience was not a pre-specified secondary outcome (and is therefore subject to the perils related to subgroup analysis),⁴ it was with hesitance and caution that we re-analyzed the data to

see if experience improved times to intubation in either the 90° or 60° groups (Table). Interestingly, experience of the operator did not seem to influence TTI in the 90° group, but markedly influenced TTI in the 60° group. If anything, this would tend to confirm the conclusion that the 90° stylet configuration is superior to the 60° configuration, especially when dealing with an inexperienced practitioner performing tracheal intubation with the GlideScope® videolaryngoscope.

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Airway management for intra-oral surgery - airway first!

To the Editor:

We read with interest the airway management of a patient with an intra-oral dermoid cyst as described by Raveenthiran and colleagues.¹ While the authors should be congratulated for their successful management of an anticipated difficult airway, we seek some clarifications from them. The aspiration of contents of any oral swelling should be preceded by appropriate radiological evaluation, which has not been mentioned. It is not clear whether the large size of the needle used required local or topical anesthesia. It is also not clear if the aspiration was carried out using an extra-oral (e.g., submental) approach. Furthermore, these authors' conclusions and recommendations require a word of caution. Based on the experience from a single case, the conclusions may not be extrapolated to all intra-oral cysts. There are intra-oral

TABLE Comparison of 90° and 60° degree groups by level of experience

Comparison	Mean difference (95% confidence interval of difference)	P
90° experienced vs 90° inexperienced	- 0.01 sec (-14.85 to 14.83)	> 0.05
60° experienced vs 60° inexperienced	-17.1 sec (-30.6 to -3.6)	< 0.01

One-way ANOVA with Tukey-Kramer post test. Calculated in GraphPad Prism version 4.03 for Windows.

swellings of varied pathologies (e.g., hypervascular neoplasms)² that should not be aspirated. This and the recommended airway management plan should not be applied, as stated by these authors; ‘to any huge cystic lesion of the oral cavity irrespective of its pathology’. Surgical procedures in the airway that precede a definitive airway have the potential for converting an anticipated difficult airway into a dangerously difficult airway.^{3,4} Anticipated pediatric difficult airways also require special considerations that may have been overlooked by these authors.⁵ We feel that each case should be assessed individually, and an approach determined on the basis of experience, equipment availability and situation. Ultimately, the goal should always be patient safety with the best achievable clinical outcome. We believe that, as with other scenarios, the maxim even for ‘airway management for oral surgery’ should be (literally) “airway first!”.

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Reply:

We thank Drs. Eipe and Yee for their interest in our recent Letter to the Editor. They have sought clarification regarding certain details which were omitted due

to space constraints in our original correspondence. Ultrasonography done prior to needle aspiration confirmed the cystic nature of the mass. The boy cooperated very well, and hence he did not require any form of anesthesia for needle aspiration of the cyst. One may, however, consider local or topical anesthesia according to the exigency of a given case. We did transoral aspiration as the needle had to traverse only a thin mucosa and cyst wall by this route. For the same reason, pain was minimal during the procedure.

It is unfortunate that Drs. Eipe and Yee misconstrued our conclusion. We never recommended needle aspiration of solid neoplastic lesions or vascular lesions. But we would strongly recommend this approach for benign, huge cystic lesions of the mouth. Logical extrapolation does not require a great number of cases. When the liquid content of a dermoid cyst can be aspirated, why would the same principle not be applicable to a lingual cyst or cystic hygroma with a much thinner content?

We agree that oral surgical procedures have the potential to convert a difficult airway into dangerous airway. However, fine needle aspiration is a minimally invasive procedure that does not carry the same implications as a surgical intervention. Sudden flooding of airway with cystic content, as could happen with surgical incision of a cyst, is unlikely with fine needle aspiration. Accidental rupture of a cyst due to manipulations in an “airway first” approach could be more dangerous than a needle decompression.

Drs. Eipe and Yee are right in claiming that the airway is of prime importance in oral surgery. But we would modify their maxim and state “make the airway accessible first - before securing it” in the context of achieving easy and safe airway access in the setting of large oral cysts.

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Endotracheal intubation through a laryngeal mask/supraglottic airway

To the Editor:

The Laryngeal Mask Airway™ (LMA) is an integral device in the management of the difficult airway.¹ It can be used as a rescue ventilatory device in a “cannot intubate-cannot ventilate” situation; and to provide a conduit to insert an endotracheal tube (ETT) to