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## Nasal fiberoptic intubation: what "red out"?



### Intubação por fibra óptica nasal: o que é "apagão?"

Dear Editor,

Nasotracheal intubation is an important skill that is unfortunately less practiced nowadays. We were therefore delighted to read about the technique by Rewari et al.<sup>1</sup> on facilitating fiberoptic nasotracheal intubation. We herein suggest a way to bypass the problem of "being in the dark" (referred to as "Red out" by the authors) when passing the fiberscope through the nasopharynx. In our practice, we first pass a warmed/soft and lubricated tracheal tube through a nostril into the supraglottic area prior to passing the fiberscope. In most adults, the tracheal tube would have an internal diameter of 7.0 mm. The average distance at which the tip of the tube would be just at the laryngeal inlet would be 15–17 cm as measured at the ala nasi. For a spontaneously breathing patient, this distance is at which further advancement would result either in successful tracheal intubation, or, as is more often the case, loss of exhaled air through the tube. It is at this point when we pass the fiberscope within the lumen of the tracheal tube. At the same depth of insertion, the larynx is sometimes immediately in the fiberscope view, at which point the fiberscope is advanced further into the trachea. If the larynx does not immediately come into view, the fiberscope tip could either be manipulated accordingly, or 20–30 mL of air is injected into the tracheal tube cuff, if present, to elevate the tip of the tube such that it points to the larynx. During cuff inflation, the operator keeps an eye on the fiberscope view and the larynx often becomes visible at which point the inflation of the cuff stops and the fiberscope is advanced into the trachea. This technique is easy to execute and does not have the drawback of having to guide the fiberscope pass the dark passage of the upper respiratory tract.

Furthermore, we respectfully disagree with the authors that "awake nasal fiberoptic intubation is the technique of choice in an anticipated difficult airway". While we agree that awake fiberoptic intubation remains the ultimate technique for difficult intubation, even in the current era of videolaryngoscopy, orotracheal (rather than nasotracheal) intubation remains the preferred technique in most clinical settings.

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## Conflicts of interest

The authors declare no conflicts of interest.

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