The Laryngoscope

Letter to the Editor

In Response to *Assessing the Performance of the Shikani Optical Stylet for Awake Nasal Intubation*

In Reply:

We thank Tian et al. for their comments on our recent article. We carefully assessed these comments and responded below.

First, Arné et al. designed their scoring system for predicting difficult intubation by direct laryngoscopy, which is precisely the scenario warranting advanced devices, including fiberoptic bronchoscope (FOB).[1] Difficult Airway Society guidelines recommend that awake intubation should be considered in the presence of predictors of difficult airways, such as patients with head and neck pathology, reduced mouth opening, and limited neck extension.[2] These factors are also included in the Arné et al. scoring system. Therefore, we used their scoring system to identify patients with a highly probable difficult intubation with direct laryngoscopy to justify using Shikani optical stylet or FOB.

Second, we concur that operator proficiency with the studied devices could have a substantial effect on procedural outcomes. There is yet no agreement on the definition of experienced operators. Previous studies have indicated "experienced operators" to have more than 1, 3, or 5 years of clinical experience or to have performed more than 20 or 50 intubations.[3–8] The Chinese Society of Anesthesiology guideline recommends that difficult intubation should be performed by a skilled anesthetist with more than 5 years of experience.[9] Hence, in our study, intubations were performed by anesthetists who had more than 5 years of experience in anesthesia and nasotracheal intubation. Furthermore, as we mentioned in our article, the operators' skills in applying the studied devices were gained through "on-the-job" experiential learning. At our institution, we perform over an average of 4,000 nasal intubations in head and neck patients a year. This provides our operators abundant opportunities for training to use both devices. Thus, by the start of the study, participating operators had used each device on hundreds of patients during their more than 5 years of experience. Finally, in our study, potential bias was minimized because operators were randomly assigned to either group.

Regarding the last point, as we mentioned, the postoperative follow-up did not assess patient comfort. In the discussion of our article, we stressed this limitation of our study. In our study, sedation was induced using midazolam. We were concerned that the subsequent anterograde amnesia caused by midazolam may affect the memory of the intubation procedure. As indicated in our article, we compared the incidence of body resistance or movement during intubation, which could be considered as severe discomfort, and no significant differences were observed between the two groups.

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