

A non-airway management use of the video laryngoscope (GlideScope®)

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EDITOR:

We report a case in which we used the GlideScope® to facilitate the successful insertion of nasogastric tube.

A 66-yr-old male was scheduled for an elective left-sided hemi-mandibulectomy with radial free flap reconstruction for squamous cell carcinoma of the oral cavity. On assessment, the patient's airway was Mallampati 2 and mouth opening was three finger-breadths wide. We induced anaesthesia and intubated the trachea (Cormack & Lehane grade 2 on direct laryngoscopy). We attempted and failed to insert a nasogastric tube with digital manipulation as well as under direct vision with a MacIntosh blade. At this point, we inserted the video laryngoscope (Glide-Scope®). The view was Cormack & Lehane grade 1 of the laryngeal inlet with an endotracheal tube *in situ*. We lifted the epiglottis with the GlideScope tip, which improved the view of entrance to the oesophagus. We could insert the nasogastric tube under direct vision with digital manipulation. The position was confirmed with gastric contents on aspiration and the appropriate pH of the aspirate.

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The GlideScope has been designed to facilitate tracheal intubation by achieving a clear view of the anterior segment of the glottis without the need for a direct line sight. Even in difficult intubations, the GlideScope achieves Cormack & Lehane view I and II in 99% of patients [1]. It requires less force than conventional laryngoscopy, hence it is less traumatic and minimizes the laryngoscopic stress response. Its slim blade provides a good working space not only for intubation, but also for nasogastric tube placement. It is easy to learn, use and master the technique.

Even though there are no clinical trials available to support this use, it may be a useful technique to use the GlideScope to insert a nasogastric tube, especially in intubated patients. It may also theoretically reduce the stress response to laryngoscopy as it requires less force than the traditional laryngoscope.

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Reference

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Lactate gap and ethylene glycol poisoning

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EDITOR:

We assayed lactate levels in plasma using point-of-care analysers and obtained a fallaciously high value when compared to the value obtained from the central laboratory. The divergence in the lactate values suggested the possibility of ethylene glycol poisoning, but due to the limited information valuable time was lost in initiating treatment.

A 36-yr-old male was brought to the hospital in an unconscious state with a core temperature of

32.9°C. Glasgow coma score on arrival in the accident and emergency department was 3. Clinical evaluation and an urgent computed tomography (CT) scan of the head ruled out intracranial pathology. The patient was moved to the critical care unit for further management.

Blood gas analysis breathing 50% oxygen showed a pH of 6.8, PCO₂ 1.4 kPa, PO₂ 34 kPa, HCO₃⁻ 1.0 mmol L⁻¹, base excess -26 mmol L⁻¹ and lactate 33 mmol L⁻¹. Routine blood tests showed a lactate of 15.8 mmol L⁻¹. Past medical history revealed a suicidal tendency with previous admission to the hospital with paracetamol overdose. Toxicology screening was sent. A portable ultrasound of the abdomen was performed and contrast CT was planned to rule out intra-abdominal conditions. Fluid resuscitation,

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