Published in final edited form as:

Crit Care Med. 2017 April ; 45(4): e463. doi:10.1097/CCM.0000000000002270.

Reply: Video Laryngoscopy for Endotracheal Intubation of Critically Ill Adults - Role of Different Blades & Stylets

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We appreciate the letter to the editor by Latif et al (1) regarding our recent FELLOW trial of video laryngoscopy (VL) versus direct laryngoscopy (DL) for endotracheal intubation of critically ill adults (2).

Latif et al raise the point of whether an experiment was performed in the FELLOW trial. In this trial, 98.6% of VL intubations were performed with the McGrath[®] MAC video laryngoscope and 94.7% of DL intubations were performed with curved blades. Despite an experiment having occurred in the FELLOW trial (VL group having significantly better glottic visualization), Latif et al argue that glottic visualization is not as meaningful regarding increased procedural success as the angulation of the VL blade. Unfortunately, supposition that the angle of the blade rather than glottic view is the truly meaningful intervention is only speculative and this assertion differs from the fundamental argument in favor of VL expressed by experts, specifically that VL provides a superior view of the glottis (3). In addition, the existing data from randomized trials of devices with hyperangulated blades mentioned by Latif et al all show that these hyperangulated blades do not improve success (4) or may even be harmful (5). Finally, Latif et al cite a previous study (6) using GlideScope[®] as the only VL device as evidence that hyperangulated blades may be superior to direct laryngoscopes with curved blades. We would point out that the conclusion of the study's authors was that the differences between VL and DL were related to differences in glottic view with no mention of blade angle and that the large effect size seen in this previous study was likely due to a lack of randomization and no use of neuromuscular blockade.

Acknowledgments

Source of Funding: Investigators were supported by a National Heart, Lung, and Blood Institute (NHLBI) T32 award (HL087738 09).

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Authors contributions: Drafting and revision of the manuscript: D.R.J., M.W.S., and T.W.R.

Conflicts of Interest: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. The authors declare no potential conflicts of interest. T.W.R. reported serving on an advisory board for Avisa Pharma, LLC, as a DSMB member for GlaxoSmithKline PLC, and as Director of Medical Affairs for Cumberland Pharmaceuticals, Inc.

Copyright form disclosure: Dr. Janz's institution received funding from the National Institutes of Health (NIH). He received support for article research from the NIH. Dr. Semler received support for article research from the NIH. Dr. Rice received support for article research from the NIH. He received funding from GlaxoSmithKline, Avisa Pharma, and Cumberland Pharmaceuticals.

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