

PROCEEDINGS BOOK

PROGRAMME

08:00-08:30	**Registration**
08:30 – 08:45	**Welcome and introduction** ***Antigona HASANI (Prishtina/Kosova) & Rifat LATIFI (New York/USA)***
08:45-09.00	**Coffee break**
09:00-09:30	**Surgical airway in COVID-19 patients** *Rifat LATIFI (New York/USA)*
10:00-10:30	**Airway management in COVID-19 patients** *Vedat ELJEZI (Clermont-Ferrand/France)*
10:30-11:00	**Supraglottic airway devices** *Gamze ÇABAKLI (Istanbul/TURKEY)*
11:00 – 11:30	**Lighted stylets in difficult airway management** *Ruslan ABDULLAYEV (Istanbul/TURKEY)*
11:30 – 12:00	**Pediatric difficult airway in anatomic abnormalities** *Ayten SARAÇOĞLU (Istanbul/Turkey)*
12:00 – 13:30	**Lunch**
13:30-14:00	**Difficult airway in emergency department and intensive care unit** *Kemal Tolga SARAÇOĞLU (Istanbul/Turkey)*
14:30 – 15:00	**Changing priorities C before A** *Bellal JOSEPH (USA)*
15:00 – 15:30	**Surgical management of difficult airway** *Mentor AHMETI (USA)*
15:30 – 16:00	**Discussion**
16:00-17:00	**Remarks & Closing** **Delivery of certificate of attendance**



Lighted Stylets in Difficult Airway Management

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Although the first use of illuminated introducer dates to 1957 when Sir Robert Macintosh used it to guide intubation via laryngoscopy, the first use of conventional lighted stylet (LS) designed for blind intubation was by Yamamura et al. in 1959 (1,2). He described a bulb-tipped wire inserted into the tracheal tube that was used for blind nasal intubation. Many commercially available devices have been developed since then, including Tube-Stat™ (Xomed, Jacksonville, FL), Imagica™ (Fiberoptic Medical Products, Allentown, PA), and Trachlight™ (Laerdal, Armonk, NY). With slight differences in design, they rely on the same principle of transtracheal illumination. The technique is very easily learned, and many studies have demonstrated good results regarding intubation success, duration of intubation, sympathetic nervous system stimulation, and complications, when compared with the conventional laryngoscopy (3-5). Basic technique involves blind insertion of the endotracheal tube-loaded LS through oral or nasal route into the trachea and then pulling the introducer back after observing the transillumination light on the patient's anterior neck. Hybrid technique have been used, including use with direct laryngoscopy, laryngeal mask airway, fiberoptic scope, and airway introducer as well. LS technique can be used in difficult intubation

situations in operating rooms, intensive care units, emergency settings, austere environments as well. Weis et al. (4) have demonstrated successful intubation via LS in 20 patients who were impossible to intubate by direct laryngoscopy. Hung et al. (6) have intubated 263 of 265 patients with anticipated or unexpected difficult airway via LS. Contraindications for use are upper airway foreign body, tumor, or polyp; retropharyngeal abscess; friable tissue; laryngeal trauma; planned fiberoptic examination due to concern of bleeding. Complications include upper airway trauma, including bleeding, sore throat, hoarseness, dysphagia, dental trauma, laceration, arytenoid dislocation; but these are encountered less when compared with direct laryngoscopy (5,7). Recommendations for LS use in managing difficult airways have been incorporated into many national and international practice guidelines, including American Society of Anesthesiologists Task Force on Management of the Difficult Airway, Canadian Airway Focus Group. Some national survey results have demonstrated the availability of LS between 10-54% in their clinics. More importantly, some survey results have demonstrated that only half of the clinic directors had experience with the device. Considering that the device is cost-effective, easily learned and have great success rates in difficult intubation conditions, I think that its training should be incorporated into the standard training curriculum of Anesthesiology, Intensive Care, and Emergency Medicine practices.

References

1. Davis L, Cook-Sather SD, Schreiner MS. Lighted Stylet Tracheal Intubation: A Review. Anesth Analg 2000;90:745–56.

2. Yamamura H, Yamamoto T, Kamiyama M. Current comment. Anesthesiology 1959;20:221.

3. Ellis ET, Jakymec A, Kaplan RM, et al. Guided orotracheal intubation in the operating room using a lighted stylet: a comparison with direct laryngoscopic technique. Anesthesiology 1986;64:827– 6.

4. Weis FR, Hatton MN. Intubation by use of the light wand: experience in 253 patients. J Oral Maxillofac Surg 1989;47:577–80.

5. Hung OR, Pytka S, Morris I, et al. Clinical trial of a new lightwand device (Trachlight) to intubate the trachea. Anesthesiology 1995;83:509–14.

6. Hung OR, Pytka S, Morris I, et al. Lightwand intubation: II - Clinical trial of a new lightwand for tracheal intubation in patients with difficult airways Can J Anaesth 1995;42:826–30.

7. Friedman PG, Rosenberg MK, Lebonbom-Mansour M. A comparison of light wand and suspension laryngoscopic intubation techniques in outpatients. Anesth Analg 1997;85:578–82.