Author’s response to reviews

Title: Comparison of the Airtraq laryngoscope and the GlideScope for double-lumen tube intubation in patients with predicted normal airways: a prospective randomized trial

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Author’s response to reviews:

To reviewer 1,

1. Major compulsory revisions

   Line 142-143: in any case comparison between videolaryngoscopes should have been performed better on same DLT size. Data for distribution of sizes in two groups would be recommended (larger tube could be more difficult to insert). They could be integrated in table 2.

   This suggestion is very important. We’ve added the data of DLT sizes in table 2, including the distribution of DLTs sizes and its comparison between two groups.

2. Minor Revisions

   1) Line 76-77: for precision, only Glidescope has integrated video camera, while this option is available only with external accessory on airtraq

   We are so sorry for this confusing sentence and we have made it clear with the statements of “Their common features include specially designed blades and the video cameras, integrated into the GlideScope blade or as external accessory attached onto the Airtraq Laryngoscope, which provide better laryngeal views”.

   2) Line 82: the literatures have-#Literature has,

   We replaced the sentence in line 83.

   3) Line 119: better to add reference for guidelines or criteria adopted for definition of difficult airways (see below ref16)

   We are sorry to make this mistake. In fact, we wanted to present the exclusion criteria that the “patients with histories of failed or difficult intubation” rather than “identified difficult airways”. So we made it clear and replaced the sentence in lines 118-119.
4) Line 120-121: more than contraindication for videolaryngoscopes it is more indication for flexible awake fiberoptic. Anyway less than 3cm mouth opening is someway already part of definition of difficult airways, thus resulting per se exclusion criteria. I would clarify this sentence.

We have clarified the definition of difficult airway in detail as in reference 16, which included the mouth opening, Mallampati scores, thyromental distance, etc. Please find the correction in lines 120-122. We are sorry for making this confused expression.

5) Lines 137: useful to specify which condition was expected on NMT monitoring in both groups.

Thanks for the reviewer’s suggestion. We have added the detailed condition of NMT monitoring in lines 136-138.

6) Line 139: CL grading was designed for Macintosh blade, on “line of sight” principle. Comparison with videolaryngoscopes using CL could be unfair and always strongly preferring videolaryngoscopes. It would have been interesting to add other measurement for videolaryngoscopes, such as Freemantle score or POGO so to compare more “balanced way” videolaryngoscope performance. Could add some comments here or in section for discussion (lines 282).

We totally agree with the reviewer that POGO is another good parameter to assess the laryngeal view. It will be perfect, indeed, to measure the glottis view with POGO and CL grading together. However, in this study, we only chose the CL grading because we assessed the glottis exposure twice, initially with the Macintosh blade and then with the GlideScope or Airtraq. In this setting, CL grading was probably considered as a fundamental measurement comparing with Macintosh laryngoscope. Additionally, the CL grading is very familiar and easy to understand to anesthesiologists. We added some comments in discussion in lines 267-273.

7) Line 216: comment could be added, either here or in discussion, for typical situation with videolaryngoscopes in which a better view(if compared with Macintosh) does not correspond directly with better intubation.

We totally agree with the reviewer that the better glottis provided with videolaryngoscopes may not be associated with better intubation. In discussion, we have added the comment in the 4th paragraph in line 284 and corresponding references (Ref. 26, 27).

8) Line 138: reference 20 typing mistake,”lumenendobronchial”

We corrected the mistake (line 447 reference 21) and so sorry for this mistake.

To reviewer 2.

1. In some part of the manuscript one of the devices has been called ‘Airtraq DL’ and in some parts ‘Airtraq laryngoscope’. If there is a special blade of Airtraq for
DLT, it should be called everywhere in the text as ‘Airtraq DL’. Actually there is no such product of Airtraq, when you check the website www.airtraq.com. If there is a such product which is not commercially available, you have to put its photo with a regular Airtraq blade to show the difference. If it is the case then you have to change the key word as Airtraq DL.

We are so sorry for leading to a confusion of the different Airtraq names. Actually, the Airtraq laryngoscope is the name of a disposable laryngoscope series with different types and sizes which are suitable for oral, nasal, pediatrics or double lumen tube intubations. The Airtraq laryngoscope in our study is for double lumen tube intubation and previously called Airtraq DL (DL means double lumen, see ref. 1) or the DLT Airtraq (see ref. 2). In the paper, we have changed all the names into “the Airtraq laryngoscope” as the reviewer suggested.


2. You have to indicate the type of DLT used. I mean left sided or right sided. If it is not comparable between groups there should be a lot comments. Maybe to insert left sided is much more easier with one of the device or vice versa.

Thanks so much for this comment. Yes, it is very important to indicate the type of DLT. We have added the type of DLTs selection in the section of Method (see lines 142-144). Also, we have integrated the data of tube type with comparison of two groups in table 2.

3. If you have used the stylet of DLT in order to fit the angle of the blade you have to indicate it. If you have used another stylet you have to define it.

Indeed, we should identify the stylet used in the study. Actually, the stylet we used was the original one assembled inside the DLT. Please find the revised content in lines 145 and 150.

4. It should be expected that the cardiovascular response to the airway management with Glidescope would be more significant with long duration as the manipulation within upper airway is much more with Glidescope than Airtraq.

We appreciate the reviewer’s opinion which is similar to ours. It is true that the cardiovascular responses were greater with Glidescope in our study.