

renal function significantly improved. On day 12, artificial ventilation was discontinued and the endotracheal tube was removed. On day 30, the patient, now conscious, in logical contact and enterally fed, was transferred to the Department of Otolaryngology. One year after the completion of treatment the patient resumed his professional activities.

High concentrations of PCT in patients treated for septic shock have been well documented in the literature; however, in the majority of cases they correlated with ICU mortality [3–5]. Single reports have also described high concentrations of PCT in patients intoxicated with amphetamine [5]. In our case, a high concentration of PCT on day 1 of hospitalisation might have suggested an unfavourable prognosis. A relatively quick improvement of the patient's general condition and significantly reduced concentrations of PCT during the first days of treatment did not confirm the correlation between high PCT levels and mortality. Analysis of the dynamics of PCT changes during treatment appears to be more specific. Some studies have emphasised a substantially higher correlation between the kinetics of PCT changes during the first days of treatment and the mortality of patients treated for septic shock [6–9]. In our case, reduced concentrations of PCT were observed during the first 72 hours of treatment. Therefore, it can be assumed that monitoring of the dynamics of PCT changes is a sensitive prognostic factor in patients treated for septic shock. Nevertheless, further studies are needed to demonstrate the sensitivity of changes explicitly.

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Tips and troubleshooting during intubation with AirTraq videolaryngoscope

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Editor,

The AirTraq optical laryngoscope (Podol Meditec SA, Vizcaya, Spain) is an intubation device which can be successfully used both in cases of expected [1] and unexpected [2] difficult intubation. However, in some cases it may be difficult to introduce an endotracheal tube despite good

visualisation of the glottis [3, 4]. In such cases the use of an intubation stylet [4] or a gum elastic bougie [3] is described. However, it may be barely possible to position an endotracheal tube (ET) with a stylet when in the guide channel of the AirTraq. Anaesthesiologists sometimes try to change the tube position like when using a standard Macintosh laryngoscope blade. This is not possible due to the design of the AirTraq's guide channel for an ET. If manoeuvres are necessary, they must be done with the device itself, not the ET. If the glottis is beyond the centre of view and device positioning does not improve visibility, the use of a gum elastic bougie may help [5, 6]. The gum elastic bougie should be introduced into the guide channel of the AirTraq instead of the ET. Because of its smaller diameter, it is possible to

manoeuvres it while in the guide channel of the device (Fig. 1). As the tip of the gum elastic bougie is curved, it may help to introduce it to the glottis (Fig. 2). As this manoeuvre is similar to using a bougie with a standard Macintosh blade



Figure 1. AirTraq optical videolaryngoscope with gum elastic bougie stylet introduced into endotracheal tube guide channel

laryngoscope, it would seem to be easy to learn by an anaesthesiologist who is experienced with using a bougie. When located inside trachea, a bougie is used as a guidewire to introduce an ET. Sometimes, it may be helpful to introduce the ET together with a gum elastic bougie and use the bougie only to direct the ET towards the larynx [7]. This technique may be used not only when the larynx is out-of-centre of the view but also when moving the head is not advised.

Another difficulty that anaesthesiologists may face when using the AirTraq during intubation is that the ET does not pass through the glottis, despite good visualisation of the vocal cords. This may be due to resistance created by the tip of the tube touching the anterior wall of the trachea. In this situation, it is advised to retract the ET and then introduce a gum elastic bougie into the ET via the guide channel of the AirTraq. This is followed by placing the gum elastic bougie into the trachea and introducing the ET alongside the bougie.

We tried this technique in several cases when residents stated difficulties with introducing an ET using the AirTraq. In all such cases, the combination of a gum elastic bougie and the AirTraq allowed one to intubate the patient.

The above-described technique can be also used for awake AirTraq intubation. We used this method in a patient with restricted mouth opening. Following local anaesthesia, the AirTraq Avant videolaryngoscope was introduced. Although the glottis was above the centre of view, manoeuvres with device were not possible because of the restricted space. We introduced a gum elastic bougie into the ET guide channel of the AirTraq and intubated the trachea without any disturbance.

The AirTraq can be used together with a gum elastic bougie in cases of difficulties with introducing the ET when the glottis is beyond the centre of view, as is performed us-



Figure 2. The entrance to larynx view with visible tip of gum elastic bougie

ing a fiberoptic together with a videolaryngoscope [8], but this way is cheaper and easier to perform.

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Always check anaesthetic equipment

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Sir,

Foreign bodies in the breathing system causing critical incidents and even the death of a patient have been a topic for publicity and recommendations [1–4].

Usually inert small items such as caps, bungs (plastic stoppers) and metal pieces have been reported.

We would like to emphasise the importance of checking all parts of the circuit individually. Finding an insect is rather rare.

During our routine pre-operative check, we were surprised to find this dead fly in the HME filter, which had just been taken out of a new packet (Fig. 1 A–C).

Foreign bodies can enter the equipment during wrapping, decontamination or storage. There are case reports of wrapping material or manufacturing material, such as plastic causing obstruction [5]. We believe it may have got trapped inside before packing.

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Figure 1A–C