Though the combined fiberoptic bronchoscope, video laryngoscope approach has been described in other case reports as a means of securing the airway, there are limited reports on its use in children. A 5 year old boy with a history of spinal muscular atrophy type 2 and recurrent aspiration pneumonia presented for MAGEC rod insertion for severe scoliosis. On the day of surgery his airway exam was notable for a small mouth opening and Mallampati class IV airway. Since the patient was a known prior difficult airway, we chose to use a Glidescope video laryngoscope for intubation.

General anesthesia was induced with 8% sevoflurane in 70/30 nitrous oxide/oxygen. Once IV access was secured, fentanyl and rocuronium were administered. The first attempt with a Glidescope 2 blade showed a McCormack-Lehane grade 2A view, However, we could not pass the endotracheal tube above the arytenoids. We used the Glidescope stylet on the second attempt but encountered the same problem. We chose to perform a fiberoptic intubation but were unable to visualize relevant anatomy due to copious secretions. Our next step was to use the fiberoptic bronchoscope as a flexible stylet for the Glidescope and we were able to visualize the bronchroscope passing anterior to the arytenoids on the Glidescope screen. We easily advanced the bronchoscope into the trachea with carina seen on the fiberoptic screen. The endotracheal tube passed easily over the bronchoscope. After confirming sustained end tidal carbon dioxide, the endotracheal tube was secured and the case proceeded uneventfully.

The Glidescope has been well-described as a tool that allows a higher incidence of visualization of the glottic opening with increased first pass success in several prospective studies. However, the tool has a mostly anecdotal reputation for difficulty advancing the endotracheal tube into the trachea despite the improved view of the glottic opening. Though use of the associated Gliderite stylet vastly improves ease of use, it cannot be used with smaller sized endotracheal tubes. Utilizing both the Glidescope and the fiberoptic scope allowed us to obtain a good view of the glottic opening with the Glidescope, and use that view to advance the fiberoptic scope to the glottic opening with its superior maneuverability. We were then able to confirm placement in the trachea with the visualization of the endotracheal tube with both the fiberoptic scope and the Glidescope. Due to lack of a rigid stylet for pediatric endotracheal tubes, we believe this represents an attractive option for children with difficult airways as it utilizes the best features of both technologies.

References