**VIDEO LARYNGOSCOPE**

Tracheal intubation by video laryngoscope is the most innovative advancement and a completely different experience as compared with conventional Macintosh laryngoscope, and skills needed for the former method of indirect laryngoscopy are very different from those needed for direct laryngoscopy by Macintosh or Miller blade laryngoscopes. The latter method definitely requires training to be an experienced laryngoscopist and tracheal intubator, while in case of video laryngoscopy (VL), even the novices can successfully do laryngoscopy and intubate the trachea.

Technique:

There are several potential advantages of a video image in contrast to direct laryngoscopy. The system provides high-quality video images that are enlarged on the video monitor for easier visualization. If laryngeal manipulation is required to improve visualization of laryngeal structures, the intubator and the person assisting can coordinate movements such as Sellicks maneuver as they observe simultaneously the image on the video monitor. With the video image projected from the distal end of the laryngoscope blade, laryngeal structures are kept in view as the ETT is passed through the oro-pharynx into the trachea.

The Scope is first introduced into the midline of the oral pharynx with the left hand .The epiglottis is identified on the screen and the scope is manipulated to obtain the best glottic view .The endotracheal tube is then guided into position near the tip of the laryngoscope by direct vision.When the distal tip of the endotracheal tube disappears from direct view, it should be viewed on the monitor. Gently rotate or angle the tube to redirect as needed.

COMPLICATIONS:

1.The common factor associated with intraoral injuries such as palatopharyngeal, anterior tonsillar pillar or soft palate perforations,

2. blind advancement of the endotracheal tube

3. Injuries have occurred despite apparent gentle technique and the lack of resistance encountered by the operator.

4. When upward force is applied to the Scope to achieve better laryngeal visualisation, the tonsillar pillars and related structures may be stretched taut and become susceptible to perforation

**Advantages**

1. Improved laryngeal visualization because eye and airway need not be lined up as in direct laryngoscopy
2. Less force used than during direct laryngoscopy
3. Less cervical spine movement
4. Possibly less hemodynamic stress response to laryngoscopy and intubation
5. Short learning curve
6. Improved portability and cost compared to flexible fiber optic laryngoscopes
7. Useful teaching tools
8. Generally higher success rate, especially in difficult situations.

### Disadvantages

1. Passage of the ETT may be difficult despite good view or higher POGO score; often stylet is needed
2. Fogging and secretion may obscure the view
3. Loss of depth perception
4. Economic issues over stock acquisition and maintenance
5. No single videoscope is ideal
6. Greater processing time
7. Different techniques of laryngoscopy and intubation with different makes and models

### Types of Video Laryngoscopes

* Stylets
  + Bonfils
  + Rigid and flexible laryngoscope (RIFL)
  + SensaScope
* Guide channels
  + AirTraq
  + Pentax AWS
  + Res-Q-Scope II
  + Traditional (non-guided)

GlideScope

* Coopdech VLP-100
  + Storz DCI
  + Storz C-Mac
  + McGrath

### Current videoscopes

### As of December 2010, there were six video laryngoscopes on the market in the UK, but now few more are marketed and few more are in preproduction. They are GlideScope (Standard and Ranger with different sized blades), McGrath laryngoscope, AirTraq optical laryngoscope, Daiken Medical Coopdech C-Scope VLP-100, the Storz C-Mac, Pentax AWS (airway scope), AP Advance VL, SensaScope and the Berci DCI laryngoscopes, and Co-pilot VL and King Vision video laryngoscopes to be launched.