To the Editor.—The laryngeal mask airway (LMA) can be used as an aid to tracheal intubation in a patient with difficult airway. However, removal of the LMA after endotracheal tube (ETT) placement can be difficult.

The patient was a 3-year-old, 16 kg, boy in choanal atresia planned for the transpalatal approach of choanaloplasty. He had a relatively short neck with slight limitations on flexion and extension movement. After preoxygenation, general anesthesia was induced by propofol, 3 mg/kg and vecuronium, 1.5 mg/kg. Mask ventilation was successful, but after multiple attempts via direct laryngoscopy, the glottis could not be visualized. Fiberoptic laryngoscopy was attempted once but failed because of bloody and poor vision. A size 2 LMA was inserted, inflated with 10ml air, and connected to the anesthesia circuit. After ventilation with 100% oxygen, a 4.5 mm I.D. ETT over a fiberoptic bronchoscope (FOB) was inserted into the grille of LMA and was passed into the trachea with the guidance of FOB. To facilitate removal of the LMA, we grasped the proximal end of ETT with long forceps used during suspension laryngoscopy (fig. 1). This was used to hold the ETT in place while the LMA was withdrawn over the forceps.

One of the problems with passing an ETT over an FOB through the shaft of the LMA is that a maximally inserted but still marginally long ETT does not allow for removal of the LMA over the ETT without risking extubation. Several methods have been suggested for it. These include the use of a tube exchanger, the insertion of extra-long ETT, or lengthening the ETT by taping or by inserting the tip of an ETT that has 1 mm less than I.D. of the primary ETT. The current technique should be added to this list.

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