To the Editor—We welcome Benuomo's editorial appeal for more scientific proof for the indications and contraindications for use of the laryngeal mask airway (LMA). However, the editorial itself is punctuated with dogma, unproven by scientific trial, that should be questioned before they become legalistic guidelines for clinical practice.

Several case reports, as well as the manufacturer's instructional videotape, attest to the safety of the LMA when the potential for difficult intubation is recognized. Most of these patients were their own controls in that previous attempts at intubation had been difficult. It is therefore difficult to accept Benuomo's statement that the LMA should not be used "whenever tracheal intubation cannot be accomplished readily" or when "the potential for difficult intubation is recognized." We recognize the qualification relatively contraindicated, but the only supporting reference is the unsubstantiated opinion in another editorial. Even when intubation is expected to be easy, opinions vary on when it is essential. The determining factors include the type of surgery, the patient's general condition, and the anesthesiologist's experience. The greater the experience of the anesthesiologist with the LMA in uncomplicated cases, the more confident he or she will be with its use in the difficult airway situations described in the case reports.

Conditions that contraindicate use of the LMA apply equally to patients with easy or difficult airways. These include nonfasting patients, those at high risk for regurgitation, and those with low pulmonary compliance who will require positive pressure ventilation. We would consider use of the LMA for difficult airways caused by anatomic deformities of the neck, face, or jaw, but not when the obstruction is caused by pathology of the pharynx or larynx. An example is a patient who presented to us for corrective surgery for severe old burn contractures of the face and neck with limited mouth opening; her airway was easily established and maintained by one of us (SGN) with the prototype reinforced LMA. She was typical of patients from developing countries where anesthetic equipment is limited. Fiberoptic intubation of the trachea is not possible because a fiberoptic bronchoscope is not available. Children are anesthetized with intramuscular ketamine, and anesthesia is deepened with halothane in oxygen before the LMA is inserted. The same technique has been used in an adult with similar deformity, with topical anesthesia, with or without sedation, may be equally appropriate in adults. One of us (JRM) has performed this maneuver frequently on himself for teaching and demonstration purposes after gargling with 5 ml 2% viscous lidocaine.

Some anesthesiologists may feel more comfortable if they perform awake fiberoptic intubation in every patient with a perceived difficult airway, irrespective of the type of surgery. However, the greater one's experience with the LMA, the more likely one is to use it in such cases when the patient's general condition does not contraindicate its use. When it has been placed and a clear airway exists, the question arises, "Is intubation really necessary?" One of the advantages of the LMA is that it is well tolerated and can be left in place until the patient is awake. Exuberation of the trachea may provoke coughing and laryngospasm, which may be particularly hazardous when easy reintubation cannot be guaranteed.

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(Accepted for publication February 15, 1993.)