

out on 200 children aged from six weeks to 17 yr, and weighing from 2.63 kg to 67 kg.

After induction of anaesthesia (either intravenous or inhalational), 89% of the LMAs were inserted at the first attempt, with 11% requiring two or three attempts. Of the 22 initial failures, half were due to inadequate depth of anaesthesia (often causing laryngeal spasm or coughing). Other problems included inserting the wrong size LMA, or physical difficulty in inserting the mask. After insertion of the LMA, the resulting airway was recorded as clear (silent) in 97% of cases throughout the operation. Two per cent had noisy airways, but with no other signs of obstruction were recorded. Two patients in these groups required continuous neck extension to maintain a clear airway. Laryngeal spasm developed in 1% perioperatively and necessitated tracheal intubation.

In 99.5% of cases, IPPV (assessed by gentle squeezing of the reservoir bag) was found to be satisfactory, with little or no air leak, and no distension of the stomach. The only failure was in an infant of seven weeks.

The LMA is useful in managing a difficult airway. Before this series the LMA had been used successfully to manage a case of supraglottic obstruction, but it had failed to do so in a patient with micrognathia. Mason and Bingham reported on their experiences of the LMA in children older than six months.¹ We used the LMA in nine children *younger* than this, but are cautious about recommending the use of the LMA in this age group. Airway patency was clear in only six cases (67%), and noisy in two others (22%). In one case the LMA was removed intraoperatively because of laryngeal spasm, and the patient required tracheal intubation. Two LMAs dislodged in children of this age group. The only failure of IPPV was in a seven-week infant, which was associated with dislodgement of the LMA.

Generally, we found the LMA to be safe, effective and reliable in children but urge caution in its use in infants of less than six months.

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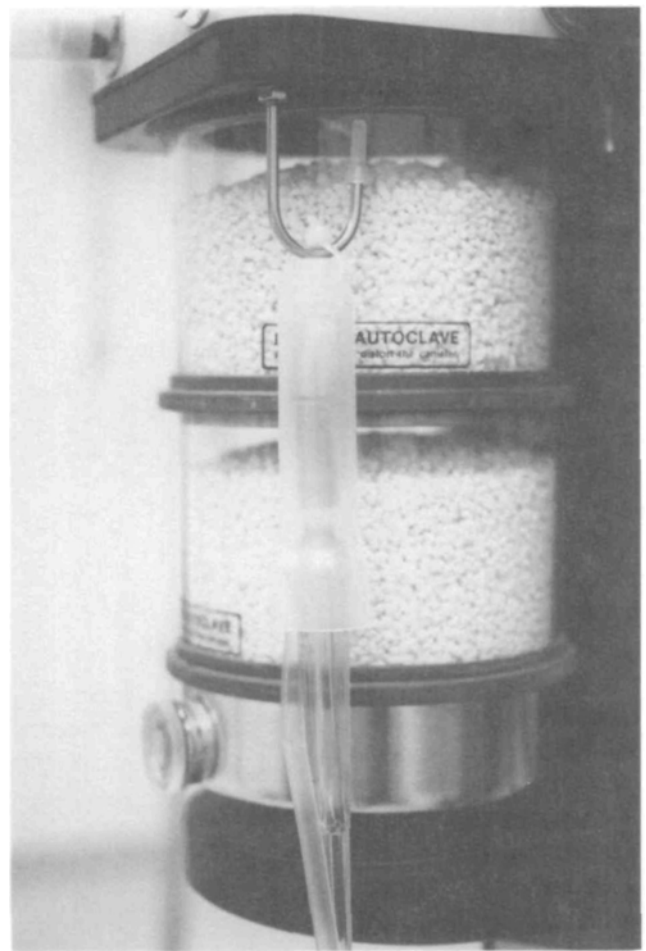
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REFERENCE

- 1 Mason DG, Bingham RM. The laryngeal mask airway in children. *Anaesthesia* 1990; 45: 760-3.



FIGURE

Suction at the ready

To the Editor:

Every anaesthetist must have suction apparatus readily at hand. For those with an anaesthesia machine with the Ohmeda® GMS absorber, we have devised a particularly useful addition that makes suction readily available, but keeps it out of the way (Figure). Two holes are cut in the end of the plastic case from a Monoject® 10- or 20-ml syringe. A cable tie is placed through the holes, connected, and placed on the U-shaped circuit hook on the GMS absorber head. The cable tie is then pulled tight and trimmed. Suction tubing can now be doubled up and inserted into the plastic case.

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