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The laryngeal mask airway as an aid to blind orotracheal intubation

To the Editor:

Couture *et al.*¹ reported a useful technique to circumvent an unpredictably difficult intubation. We encountered a similar case but used a laryngeal mask airway (LMA) to guide blind orotracheal intubation, as suggested by Heath and Allagin.² A 39-yr-old woman was admitted to hospital for elective coronary revascularization. She suffered from rheumatoid arthritis with neck pain and stiffness. Inspection of her oropharynx showed part of the uvula (Mallampati class 2), but she could not fully extend her neck.

On the morning of surgery, after fentanyl 200 µg, vecuronium 0.5 mg, and preoxygenation, we determined that the lungs could be ventilated easily by mask. Subsequently, fentanyl 15 µg·kg⁻¹ and vecuronium 0.08 mg·kg⁻¹ were administered over two minutes. Since tracheal intubation was not achieved with a Macintosh or Miller laryngoscope, or with a fiberoptic bronchoscope, we decided to make a single attempt at blind intubation guided by prior placement of an LMA. A #4 LMA was positioned over the laryngeal inlet and an effective seal was obtained with the cuff inflated. Positive pressure ventilation (up to 20 cm H₂O) was applied without leakage. The largest possible endotracheal tube (6 mm ID) was inserted through the LMA and tracheal intubation was accomplished easily.

In 1985 Brain³ described a case where the laryngeal mask facilitated blind orotracheal intubation. He stated that achieving an effective seal around the larynx was easier when the larynx was anterior. However, because of its size and tendency to fold or ensnare the epiglottis, the LMA should be removed soon after intubation is accomplished.⁴

To prevent accidental extubation during removal of the LMA, any of the standard methods of tube exchange can be employed.⁵ A standard 55-60 cm paediatric fiberoptic bronchoscope will provide a guide to withdraw the LMA and re-intubate the trachea if necessary. Alternatively, one of the newer jet stylets⁶ can be employed, or a medium Sheridan[®] tube exchanger will fit through a 6 mm ID tracheal tube and when connected to a jet injector via a 16-G intravenous catheter, that tube exchanger should provide adequate tidal volumes.⁷ Before removing the jet stylet, the anaesthetist should confirm successful re-intubation.

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Needle stick injuries

To the Editor:

I am concerned about the lack of protection for individuals who sustain needle stick and other similar injuries. Even high-risk groups are not screened for AIDS and while it is permissible to take a blood sample for hepatitis screening, without patient consent after a needle stick, it is not permissible, without first obtaining patient consent, to perform an AIDS test. Thus, the investigation of such injuries depends on the cooperation of the patient. The patient can withhold consent for AIDS testing. I believe that this needs to be changed so that AIDS testing can be dealt with in the same way as that for hepatitis.

The risk of acquiring AIDS from a needle stick has been