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The laryngeal mask airway in awake patients

To the Editor:

We read with interest the report by Williams and Bailey on the use of the laryngeal mask airway (LMA) in an awake patient for the management of failed oral fiberoptic intubation (*Canadian Journal of Anaesthesia* 1993; 40: 287). The authors state that this was the second case reported in which the LMA was inserted under topical anaesthesia and sedation. In fact, this technique has now been widely described and several authors have reported insertion of the LMA in awake volunteers or patients.¹⁻⁵ Furthermore, we have reported the use of the LMA as an aid to awake diagnostic bronchoscopy in 50 patients with topical spray, a crico-thyroid puncture and sedation.⁶ More recently, Asai has described the use of the LMA in awake patients as an aid to both rapid sequence induction and awake intubation.⁷ There is indirect evidence that LMA insertion is not compromised in the patient who is difficult to intubate.^{8,9}

The LMA can help solve the problem of the anaesthetised patient whose trachea is impossible to intubate when it can be used either as a substitute airway or as an aid to intubation.¹⁰ The report of Williams and Bailey adds further weight to an increasing body of evidence suggesting that insertion of the LMA in awake patients is easy to perform, acceptable to the patient and provides both an adequate airway and good conditions for intubation via the LMA. A particular advantage of this technique is the opportunity to induce anaesthesia before trachea intubation once a clear airway has been established with the LMA. We feel that the role of the LMA in the management of the difficult airway should probably be extended, although confirmation of this awaits the results of controlled trials. Meanwhile we would like to suggest, for an experienced operator, to consider awake insertion of the LMA as a first line approach to aid in-

tubation where difficulty is anticipated in the patient not at risk of aspiration.

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The Combitube[®] oesophageal-tracheal double lumen airway for difficult intubation

To the Editor:

The oesophageal-tracheal double lumen airway has stemmed from the concept of the oesophageal obturator airway.^{1,2} The ASA task force on the management of

FIGURE Schematic diagram of the Combitube[™] (Sheridan) in position.

the difficult airway included the Combitube[™] among the suggested contents of the portable storage contents for difficult airway management.³

Recently, we have used the Combitube[™] for the anaesthetic management of a patient whose trachea was difficult to intubate. The patient was a 21-yr-old, 90 kg man who was scheduled for appendicectomy. Following preoxygenation, anaesthesia was induced with thiopentone $5 \text{ mg} \cdot \text{kg}^{-1}$ and succinylcholine $1.5 \text{ mg} \cdot \text{kg}^{-1}$. Direct laryngoscopy failed to visualize the larynx or even the tip of the epiglottis. The difficult visualization was attributed to obesity, short neck, and a thyro-mental distance $< 3 \text{ cm}$. The Combitube[™] was inserted blindly and its two cuffs were inflated (Figure).

The oesophageal detector bulb⁴ was used to determine which limb was to be used for ventilation. The squeezed bulb remained deflated when attached to the short limb, #2, denoting oesophageal intubation, while rapid reinflation was noted when the squeezed bulb was attached to the long limb, #1. The anaesthesia circuit was then connected to the appropriate limb of the Combitube[™] (#1). Manual inflation resulted in ventilation of the two lungs as confirmed by chest auscultation, while epigastric auscultation was negative. Anaesthesia was maintained with nitrous oxide: oxygen (2:1), supplemented by succinylcholine infusion. Pulse oximetry remained $> 97\%$ throughout surgery. At the end of surgery, the succinylcholine and nitrous oxide were discontinued, and the lungs were ventilated with 100% oxygen. When the Combitube[™] was withdrawn, it was slightly tinged with blood. The patient showed uneventful recovery with no signs of gastric regurgitation or pulmonary aspiration.

This report suggests that the oesophageal-tracheal Combitube[™] can be used as an alternative to tracheal

intubation, when it is difficult to visualize the larynx and epiglottis by direct laryngoscopy. The Combitube[™] may be preferred to the laryngeal mask airway⁵ in the difficult intubation situation whenever the patient is considered to be at high risk of regurgitation of gastric contents and pulmonary aspiration.⁶⁻⁸

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Bronchial blockade to improve alveolar ventilation

To the Editor:

A 56-yr-old, 69 kg, woman, two months after right-sided orthotopic lung transplant for α -1 antitrypsin deficiency disease presented for routine fiberoptic bronchoscopy under local anaesthesia and intravenous sedation. The airway was anaesthetized using lidocaine 4% as a gargle,