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LMA for failed intubation (2)

To the Editor:

Priscu *et al.*¹ suggested that the priorities of the various failed intubation drills in obstetric patients should be changed and the LMA used at an early stage. However, it is our view that their use of the LMA in the patient reported was inappropriate and their suggestion is unjustified.

When the patient's lungs can be ventilated adequately with a face mask, the LMA confers no advantage except that jaw support is unnecessary. We agree with the view of King and Adams² that "should ventilation be easy after failed intubation in an obstetric patient, insertion of the LMA would at the very least be meddlesome." In addition, lower oesophageal sphincter pressure has been shown to be significantly lowered with the use of the LMA when compared with the use of the face mask and Guedel airway,³ thus increasing the risk of regurgitation. The studies to date on the effect of the LMA on the incidence of the regurgitation show conflicting results.^{3–5} In this context, given our present state of knowledge, we would be cautious in recommending the use of the LMA in view of the potential for regurgitation. Furthermore, since the tip of the LMA lies below the level of the cricoid cartilage when the LMA is properly positioned, application of cricoid pressure hampers correct positioning of the LMA.

When ventilation cannot be maintained after efforts at tracheal intubation have failed, the LMA could be tried. This decision should be made at an early stage, as the LMA may not always provide adequate ventilation. Whether or not cricoid pressure should be released temporarily during insertion of the LMA is controversial.^{6,7} Once the LMA is inserted, cricoid pressure must be applied continuously until airway reflexes return; recovery of spontaneous respiration does not guarantee return of airway reflexes.

Therefore, we believe that in patients at high risk of pulmonary aspiration, the LMA should not be used when

adequate ventilation can be achieved with a face mask with effective application of cricoid pressure.

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LMA for failed intubation (3)

To the Editor:

The most interesting feature of this case was the decision to convert to the LMA after adequate ventilation had been achieved with a face mask (FM). We would like to question whether this manoeuvre is appropriate in the non-fasted patient. To change from one form of airway management which has been found to be adequate with cricoid pressure (CP) applied, to an alternative where adequate oxygenation is not guaranteed is potentially hazardous. We feel this could only be advised if continued airway patency was in doubt or the risks of aspiration was considered substantially less with the alternative technique.

The concerns regarding the use of the LMA in the non-fasted patient include the interaction between CP and