Correspondence

Laryngoscopy and laryngeal mask airway insertion in children

To the Editor:

We were interested in reading the letter from Dr. Yih¹ concerning the use of a laryngoscope to facilitate laryngeal mask airway (LMA) insertion in children. We would agree with most of her observations and others have also found the technique useful.¹²⁻⁴ Our study⁴ not only confirmed that the technique is safe and effective, but we also demonstrated a more satisfactory final LMA placement with laryngoscopic insertion compared with blind insertion, as assessed by fiberoptic endoscopy. We could not demonstrate, however, any clinical advantage of one technique over the other. In everyday practice, we prefer to use gentle blind insertion as our primary technique and reserve alternative techniques, such as the rotatory method⁵ and the laryngoscopic method,²⁻⁴ should the blind method fail.

The only other comment we would make concerning the laryngoscopic method is that, unlike Dr. Yih, we used a curved (Macintosh) blade for laryngoscopy and did not routinely pass the blade past the epiglottis. Insertion of the blade in the vallecula and anterior displacement of the tongue provided good insertion conditions in our study.

Robin G. Cox MB BS FRCA FRCPC
Calgary, Alberta
Tom Elwood MD FRCPC
Seattle, Washington, USA

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The Charlottetown Click - or should it be the Carolina Maneuver?

To the Editor:

With interest, we read the correspondence by Brimacombe commenting on the Charlottetown Click technique of laryngeal mask airway (LMA) insertion. Although he agreed that this method sometimes facilitates insertion, he postulates that rotation of the cuff may lead to arytenoid dislocation. He recommends that patients who have had insertion of the LMA by this technique be followed up for speech problems.

However, perhaps the author is unaware of a previous study performed comparing two insertion techniques of the LMA.¹ Payne prospectively compared the original method described by Brain² which involved its placement with the aperture facing anteriorly to an alternative one involving insertion with the aperture initially facing posteriorly until resistance is met, at which point, it is rotated through 180 degrees. Placement of the LMA was assessed using a fiberoptic bronchoscope, as was sore throat, hoarseness and dysphagia using a 100 mm visual analog scale. The presence of blood on removal of the mask and the occurrence of laryngospasm were also documented. The use of the backward technique resulted in a higher rate of successful insertion with no difference in complications.

Linda M Collins MB FFARCSI
Himat Vaghadia MB FRCPC
Vancouver, B.C.

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Preoperatively undiagnosed paraganglioma

To the Editor:

We recently encountered a previously undiagnosed