467678 - LARYNGEAL MASK AIRWAY AND DIFFICULT AIRWAY MANAGEMENT IN CHILDREN : A REPORT OF 2 CASES

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Purpose: To report two cases with known difficult airway in children managed with the classic laryngeal mask airway (LMA) as a conduit for fiberoptic endotracheal intubation. Management of difficult removal of the LMA is discussed.

Clinical Features: After obtaining the verbal consent from the patients and parents, we describe two adolescents with known difficult airway requiring general anesthesia who were intubated using fiberoptic bronchoscope guidance using the LMA as a conduit. Subsequent LMA management was different in each case. Case #1: A 14-yr-old boy with Stickler's syndrome and mid-face hypoplasia undergoing right knee arthroplasty. Initially airway obstruction was managed with an LMA. After successful fiberoptic bronchoscopic endotracheal intubation via the LMA, the latter could not be removed. The LMA was left in place after several attempts at removal to prevent further airway edema. Case #2: A 17-yr-old girl with Treacher Collins syndrome undergoing repair of a rectovaginal fistula. After several attempts at fiberoptic intubation, an LMA was placed to manage oxygen desaturation. Endotracheal intubation was achieved by using fiberoptic bronchoscope guidance via the LMA. Different techniques for LMA removal were tried. Finally, a microlaryngeal tube, which is longer, was successfully maintained in place during LMA removal.

Conclusion: We describe two cases in which the LMA was a useful tool for airway maintenance in patients with upper airway obstruction and as a conduit for fiberoptic tracheal intubation. However, the LMA may need to be left in place if it cannot be removed after successful endotracheal intubation. Care must be taken to avoid airway edema from cuff pressure in this situation.

References: Br J Anaesth 2006;96:396-400 Anesthesiology 1999;90:1001-6 Can J Anaesth 2006;53:210-1