swellings of varied pathologies (e.g., hypervascular neoplasms)² that should not be aspirated. This and the recommended airway management plan should not be applied, as stated by these authors; 'to any huge cystic lesion of the oral cavity irrespective of its pathology'. Surgical procedures in the airway that precede a definitive airway have the potential for converting an anticipated difficult airway into a dangerously difficult airway.^{3,4} Anticipated pediatric difficult airways also require special considerations that may have been overlooked by these authors.⁵ We feel that each case should be assessed individually, and an approach determined on the basis of experience, equipment availability and situation. Ultimately, the goal should always be patient safety with the best achievable clinical outcome. We believe that; as with other scenarios, the maxim even for 'airway management for oral surgery' should be (literally) "airway first!".

Naveen Eipe MD
Doreen Yee MD
Sunnybrook Health Sciences Centre, University of
Toronto, Toronto, Canada
E-mail: neipe@yahoo.com
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Reply:

We thank Drs. Eipe and Yee for their interest in our recent Letter to the Editor. They have sought clarification regarding certain details which were omitted due

to space constraints in our original correspondence. Ultrasonography done prior to needle aspiration confirmed the cystic nature of the mass. The boy cooperated very well, and hence he did not require any form of anesthesia for needle aspiration of the cyst. One may, however, consider local or topical anesthesia according to the exigency of a given case. We did transoral aspiration as the needle had to traverse only a thin mucosa and cyst wall by this route. For the same reason, pain was minimal during the procedure.

It is unfortunate that Drs. Eipe and Yee misconstrued our conclusion. We never recommended needle aspiration of solid neoplastic lesions or vascular lesions. But we would strongly recommend this approach for benign, huge cystic lesions of the mouth. Logical extrapolation does not require a great number of cases. When the liquid content of a dermoid cyst can be aspirated, why would the same principle not be applicable to a lingual cyst or cystic hygroma with a much thinner content?

We agree that oral surgical procedures have the potential to convert a difficult airway into dangerous airway. However, fine needle aspiration is a minimally invasive procedure that does not carry the same implications as a surgical intervention. Sudden flooding of airway with cystic content, as could happen with surgical incision of a cyst, is unlikely with fine needle aspiration. Accidental rupture of a cyst due to manipulations in an "airway first" approach could be more dangerous than a needle decompression.

Drs. Eipe and Yee are right in claiming that the airway is of prime importance in oral surgery. But we would modify their maxim and state "make the airway accessible first - before securing it" in the context of achieving easy and safe airway access in the setting of large oral cysts.

Venkatachalam Raveenthiran MCh
Sam Cenita MCh
Souana K. Srinivasan MD
Rajah Muthiah Medical College, Annamalai
University, India
E-mail: vrthiran@yahoo.co.in

Endotracheal intubation through a laryngeal mask/supraglottic airway

To the Editor:

The Laryngeal Mask Airway™ (LMA) is an integral device in the management of the difficult airway.¹ It can be used as a rescue ventilatory device in a "cannot intubate-cannot ventilate" situation; and to provide a conduit to insert an endotracheal tube (ETT) to