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
Conflicts of interest and sources of support: None declared.
Accepted for publication February 16, 2007.

References

1 *Raveenthiran V, Sam CJ, Srinivasan SK.* A simple approach to airway management for a giant sublingual dermoid cyst. Can J Anesth 2006; 53: 1265–6.
2 *Liu DG, Ma XC, Li BM, Zhang JG.* Clinical study of preoperative angiography and embolization of hypervascular neoplasms in the oral and maxillofacial region. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2006; 101: 102–9.
3 *Eipe N, Pillai AD, Choudhrie A, Choudhrie R.* The tongue flap: an iatrogenic difficult airway? Anesth Analg 2006; 102: 971–3.
4 *Kummer C, Netto FS, Rizoli S, Yee D.* A review of traumatic airway injuries: potential implications for airway assessment and management. Injury 2007; 38: 27–33.
5 *Brooks P, Ree R, Rosen D, Ansermino M.* Canadian pediatric anesthesiologists prefer inhalational anesthesia to manage difficult airways. Can J Anesth 2005; 52: 285–90.

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
Souna 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

TABLE Dimensions of the laryngeal mask airway (LMA) and Intubating Laryngeal Airway™ (ILA), and the largest size of cuffed endotracheal tube (ETT) which can pass through them

Device/size	*IBW*	*Largest ETT*	*LMA/ILA length**
LMA Classic/Unique			
3	30–50 kg	6.0 mm cuffed	22 cm
4	50–70 kg	6.0 mm cuffed	22 cm
5	70–100 kg	7.0 mm cuffed	23.5 cm
ILA			
3.5	50–70 kg	7.5 mm cuffed	18 cm
4.5	70–100 kg	8.5 mm cuffed	20 cm

IBW = ideal body weight; *Distance from the external edge of the circuit connector to the internal ventilatory opening.

attain a definitive airway. Once an LMA Classic™ or Unique™ (LMA North America Inc., San Diego, CA, USA) is in position, the insertion and maintenance of an ETT tube may pose several logistic difficulties. First, the size of the ETT is limited by a) the circuit connector which cannot be removed and b) the presence of aperture bars at the ventilatory opening (Table, top). Second, the length of ETT is limited by the size of the ETT which can pass through the LMA. A 6.0-mm internal diameter ETT of 28–30 cm in length may not be long enough to be optimally positioned in mid trachea, or allow safe removal of the LMA over the ETT.

Turkstra and Pellerin reported a clever strategy to insert an ETT through a size 4 LMA Unique™ in a patient undergoing awake craniotomy.[2] By cutting off the proximal portion of the LMA and the connector, the limitation of the connector and inadequate ETT length were overcome; and they were able to insert a 6.5–mm armoured ETT over a bronchoscope into the trachea.

We wish to mention two alternative strategies to insert an ETT in patients with a supraglottic airway device *in situ*. First, the Intubating Laryngeal Airway™ (ILA, Mercury Medical, Clearwater, FL, USA) is a new, reusable supraglottic airway with functionality and insertion technique similar to an LMA.[3,4] This device has a removable circuit connector, no aperture bars at the ventilatory opening, and shorter shaft distances compared to the LMA (Table, bottom). Compared to the LMA, the Intubating Laryngeal Airway™ permits the passage of larger diameter, longer ETTs without having to sever the suppraglottic airway shaft and connector. Our experience with the Intubating Laryngeal Airway™ indicated that regular ETTs could be passed successfully into the trachea, with or without bronchoscopic guidance. The Intubating Laryngeal Airway™ may be deflated and left *in situ*; or it can be removed in a fashion similar to that of the LMA-Fastrach™.

Second, an Aintree intubation catheter (Cook® Medical Inc., Bloomington, IN, USA) is a hollow ETT exchange catheter with an internal diameter of 4.7 mm and external diameter of 6.3 mm.[5] With an LMA or supraglottic airway *in situ*, an Aintree catheter loaded on a pediatric bronchoscope can be advanced through it under bronchoscopic guidance into the trachea. The bronchoscope and the LMA/supraglottic airway are removed sequentially and an ETT is then "railroaded" over the Aintree catheter into the trachea.[6]

In unanticipated cannot intubate-cannot ventilate situations, the priority should be the establishment of ventilation by insertion of an LMA or other supraglottic airway. If effective ventilation cannot be attained, then a surgical infraglottic airway should be inserted. On the other hand, if effective ventilation is established, instead of removing the supraglottic airway and attempting alternative intubating devices, one can insert an ETT or Aintree catheter through the supraglottic device using one of the two strategies stated above. Familiarity with these techniques in routine situations would permit their usage in unanticipated difficult airway situations.

David T. Wong MD
Glenn P. McGuire MD
Toronto Western Hospital, University of Toronto, Toronto, Canada
E-mail: david.wong@uhn.on.ca
Accepted for publication February 23, 2007.

References

1 *American Society of Anesthesiologists Task Force on Management of the Difficult Airway.* Practice guidelines for management of the difficult airway: an updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. Anesthesiology 2003; 98: 1269–77.

2 *Turkstra TP, Pellerin HG.* Modification of the LMA-Unique to facilitate endotracheal intubation (Letter). Can J Anesth 2006; 53: 1266–7.

3 Mercury Medical®, The Cookgas® ILA™ intubating laryngeal airway and removal stylet. Available from URL; http://66.77.149.134/pdf_edu/EnglishILA.pdf (accessed December 9, 2006).

4 *Klein MT, Jones J.* Utility of the Intubating Laryngeal Airway®: report of an observational study. Anesthesiology 2005; 103: A846 (abstract).

5 Cook® Critical Care Products. Aintree intubation cath-

eters. Available from URL; http://www.cookmedical.com/cc/dataSheet.do?id=1314 (accessed December 9, 2006).
6 *Zura A, Doyle DJ, Orlandi M.* Use of the Aintree intubation catheter in a patient with an unexpected difficult airway. Can J Anesth 2005; 52: 646–9.

Reply:

"Any Harbour in a Storm"

We are honoured by the interest in our letter[1] by Drs. Wong and McGuire. Of the laryngeal mask airway (LMA) limitations identified by Osborn,[2] Turkstra,[1] and Wong and McGuire, the circuit connector is the most hindering.

Our purpose had been to inform anesthesiologists of a novel airway technique; Wong and McGuire suggest two other potential techniques that could be considered if a supraglottic device is present and intubation becomes necessary. The Intubating Laryngeal Airway™ (LMA North America, San Diego, CA, USA) could have advantages over the LMA-Unique™, as proffered by Wong and McGuire. However, the ILA™ has only recently been approved and hospital availability is limited compared to LMA™ products. The ILA™ was not approved for use when the events described in our letter took place. Hopefully the advantages proposed by Wong and McGuire will lead to wider acceptance and accessibility of the ILA™ devices. Note that the ILA™ has recently been approved in a disposable form, the air-Q™.

We concur that the Aintree intubation catheter (Cook Inc, Stouffville, ON, Canada) is an excellent option for intubating patients who have a supra-glottic airway in place, as previously described by several authors.[3,4] The Aintree device is easier to advance through the LMA than an ETT, and the potential to oxygenate the patient with the Aintree catheter should not be overlooked.

We did not describe a "cannot intubate-cannot ventilate" (CICV) situation, but a contaminated supraglottic airway with difficult fibre-optic laryngoscopy and restricted access (easy ventilation). That being said, we would add that, if ventilation through a supraglottic airway is inadequate, leading to CICV, one should also consider fibre-optic guided intubation,[5] free-hand or through the supra-glottic airway. If possible, it may be quicker than a surgical option.

"Any harbour in a storm" is sage advice; hopefully our technique and those advanced by Wong and McGuire can provide haven to a colleague in need.

Timothy P. Turkstra MD M Eng FRCPC
Hélène G. Pellerin MD FRCPC
London Health Sciences Centre – University Hospital, University of Western Ontario, London, Canada
E-mail: timothy.turkstra@londonhospitals.ca

References

1 *Turkstra TP, Pellerin HG.* Modification of the LMA-Unique to facilitate endotracheal intubation (Letter). Can J Anesth 2006; 53: 1266–7.
2 *Osborn IP, Soper R.* It's a disposable LMA, just cut it shorter – for fiberoptic intubation, Anesth Analg 2003; 97: 299–300.
3 *Higgs A, Clark E, Premraj K.* Low-skill fibreoptic intubation: use of the Aintree catheter with the classic LMA. Anaesthesia 2005; 60: 915–20.
4 *Cook TM, Silsby J, Simpson TP.* Airway rescue in acute upper airway obstruction using a ProSeal laryngeal mask airway and an Aintree catheter: a review of the ProSeal laryngeal mask airway in the management of the difficult airway, Anaesthesia 2005; 60: 1129–36.
5 *American Society of Anesthesiologists Task Force on Management of the Difficult Airway.* Practice guidelines for management of the difficult airway: an updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. Anesthesiology 2003; 98: 1269–77.

The Esophageal-Tracheal Combitube® and esophageal injuries

To the Editor:

We read with interest the article of Vezina *et al.* "Complications associated with the Esophageal-Tracheal Combitube® in the pre-hospital setting."[1] It would be of interest to know which Combitube sizes were used for the patients who experienced complications. The authors collected data regarding Combitube size, but did not report the findings.

The Combitube is available in two sizes: small adult (SA) Combitube (37 Fr), recommended for patients with a height between 120 to 180 cm, and the large adult Combitube (41 Fr) for patients taller than 180 cm, with an overlap between both sizes.[2] The external diameter of the Combitube 41 Fr is relatively large, and may constitute a potential risk for damage to soft tissue. It has been recommended that the SA Combitube (37 Fr) be used independent of an upper height limit.[3,4] Due to its smaller size, the SA Combitube (37 Fr) is easier to use, and may be less traumatic to soft tissues.