Correspondence

Success of the Cobra™ after failure of the Fastrach™ in the difficult airway

To the Editor:

We describe successful intubation via the Cobra™ perilaryngeal airway (CPLA; Engineered Medical Systems, Inc., Indianapolis, IN, USA)¹ after unsuccessful intubation via the Fastrach™ intubating laryngeal mask airway (ILMA; Laryngeal Mask Company, San Diego, CA, USA)² following failed laryngoscope-guided tracheal intubation.

An obese 42-yr-old male with controlled hypertension was scheduled for an inguinal hernia repair. On examination he had a predicted difficult airway (limited head and neck movement, a thyromental distance < 6 cm, but good mouth opening) and refused both regional anesthesia and an awake tracheal intubation. He had no symptoms of reflux. He was premedicated with temazepam 20 mg *po* and metoclopramide 10 mg *po* and underwent an uneventful gaseous induction with sevoflurane 6% in O₂. Facemask ventilation proved easy and suxamethonium 1 mg·kg⁻¹ *iv* was administered; however, laryngoscope-guided tracheal intubation failed after three attempts (Cormack and Lehane 3). A size 5 ILMA was inserted to facilitate lightwand-guided tracheal intubation, a technique which has been shown to be effective for airway rescue.³ Ventilation with the ILMA was easy and the expired tidal volume was 8 mL·kg⁻¹ without an oropharyngeal leak. A size 8 mm internal diameter straight silicone tracheal tube (TT) was primed with a flexible lightwand (FLW) so that the bulb was at the distal end. A supplementary dose of suxamethonium was administered. The TT-FLW was inserted through the ILMA and advanced 1 cm beyond the epiglottic elevating bar. A bright glow of light was seen in the left lateral area of the neck and the ILMA handle was rotated to the right until the bright glow was in the midline at the level of the larynx. The TT-FLW was advanced 8 cm without tactile resistance, but esophageal intubation occurred, as indicated by an absence of lightglow at the suprasternal notch during advancement.⁴ The TT-FLW was withdrawn and readvanced while the ILMA handle was elevated, but esophageal intubation occurred twice more. The size 5 ILMA was replaced with a size 4, but with the same result. The

ILMA was then replaced with a size 5 CPLA, which was inserted easily and provided adequate ventilation. On this occasion the TT-FLW advanced into the trachea at the first attempt, as indicated by the lightglow disappearing at the level of the suprasternal notch. The FLW was removed, the TT cuff inflated and correct placement confirmed by movement of the bag and capnography. The minimal SpO₂ was 95% and anesthesia management was otherwise uneventful.

The probable explanation for the success of the CPLA is that it sits in a slightly different position in the pharynx, and the angle at which the TT emerges from the distal aperture is also slightly different. As such, we postulate that there will be scenarios where the CPLA fails and the ILMA succeeds as an airway intubator. If one extraglottic device fails, another may always succeed.

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