Management of failed oral fibreoptic intubation with laryngeal mask airway insertion under topical anaesthesia

To the Editor:

Awake nasal or oral intubation of the trachea under fibreoptic guidance is accepted as a safe and effective method in cases of suspected difficult intubation. During nasal surgery an oral tube is required and the technically more difficult oral approach must be used.

We recently encountered such a problem in a patient with severe ankylosing spondylitis listed for nasal polypectomy and bilateral antral washouts. After *im* premedication with papaveretum 15 mg and hyoscine 0.3 mg and *iv* sedation with droperidol 10 mg and alfentanil 0.5 mg, his tongue and oropharynx were sprayed with lidocaine 10% (total dose 100 mg) and 2 ml lidocaine 4% was injected via cricothyroid puncture. Oral intubation with fibreoptic guidance failed as it proved impossible to enter the anteriorly placed larynx.

Therefore a size #4 laryngeal mask airway (LMA) was inserted and its cuff inflated which produced a clear airway with no patient discomfort. Anaesthesia was induced with thiopentone 15 mg and maintained with 30% oxygen in 70% nitrous oxide and halothane 1–1.5% with spontaneous ventilation. An oropharyngeal pack was inserted and Moffett's solution instilled into the nasal cavities.

At the end of surgery the pack was removed under direct vision. No blood was seen in the oropharynx. The LMA was left *in situ* until rejected spontaneously by the patient. At no time was the peripheral oxygen saturation less than 98%.

Although the LMA is known not to protect the larynx from reflux of gastric contents¹ it has been shown to prevent dye placed in the oropharynx from entering the larynx.²

This is the second case reported³ describing LMA insertion under topical anaesthesia and sedation. It is a useful technique to employ when presented with abnormal approach to the larynx as the LMA can secure the airway from before the loss of consciousness until recovery of upper airway reflexes. Alternatively, the LMA can be used to aid awake tracheal intubation by guiding a gum elastic bougie³ or fibreoptic scope into the larynx.

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Patient recruitment for clinical research

To the Editor:

The following situation illustrates some problems associated with patient recruitment for clinical research that have not been fully addressed.

A randomized study comparing three ocular block techniques for cataract surgery was conducted at our Eye Care Centre (ECC). The protocol of the study dictated that all consecutive patients of the participating surgeon, who were eligible for surgery at the Centre, be included with no exceptions. The patients were made aware of the study when seen by the surgeon in the office, and informed consent was obtained when they arrived at the ECC on the day of surgery.

A 59-yr-old East Indian patient, who did not comprehend English, was accompanied by his son as interpreter. He was in apparent good health. Informed consent was obtained via his son. Before the anaesthetic block was administered, the patient suddenly became unresponsive, with eyes open and glaring upwards, lasting a minute, with no changes in ECG, BP, or SPO₂. There was no residual neurological deficit. At the request of the patient, through his son, we proceeded with the block and surgery with no complications. Following several similar episodes of lapses of consciousness on the fourth post-operative day, the patient was admitted to a community hospital. The CT head scan, EEG and 24-hr Holter cardiac monitoring were all normal. The diagnosis was petit mal absence epilepsy.

Several issues arise from this experience. Should surgery have been cancelled? To continue with surgery, especially when the nature of the complication was not clear, might put the study and the patient at further risk. The "no exclusion" clause in the study protocol should not ever have been considered. We proceeded with