Correspondence

Management of the 'anesthetized but cannot-ventilate' situation

To the Editor:
I read with interest the case report by JR Boyce[1] entitled: "Poor Man's LMA: achieving adequate ventilation with a poor mask seal ". Mask ventilation could not be performed adequately because of the air leak due to the patient's beard and facial deformity. With the help of an assistant, the anesthesiologist could ventilate successfully by using a cuffed endotracheal tube like a cuffed oropharyngeal airway. Fortunately, intubation under direct laryngoscopy was accomplished easily.

There was a similar and earlier report on the ventilation through a cuffed endotracheal tube inserted in the pharynx.[2] With the technique described,[1,2] we can 'buy time' only for a limited duration, a major disadvantage in the 'cannot-ventilate, cannot-intubate' or 'cannot-ventilate, hard-to-intubate' situation. Boyce described the laryngeal mask airway (LMA) as just one of the useful options.[1] We believe the LMA's utility and versatility is being underestimated. Use of the LMA frees the anesthesiologist's hands for other vital tasks.[3] A LMA may be used repeatedly to preoxygenate before attempting to intubate,[4] in the same way a conventional mask is used before direct laryngoscopy. According to the ASA difficult airway algorithm, the LMA can be used as a fibreoptic conduit or ventilatory device by itself during difficult airway management.[3] Even if the intubating LMA is not available, a conventional LMA can be used as a conduit for tracheal intubation in a patient with a difficult airway.[3] The flexible LMA, if available, can improve intraoral surgical access and, in addition, has a protective effect against blood aspiration during oral surgery.[5] The recently introduced Proseal-LMA appears to improve our ability to apply positive pressure ventilation.

In brief, the LMA is not a special airway equipment anymore. It should be included in the anesthesiologists routine material, and, in the absence of periglottic pathology,[3] we believe it should be the first choice in the 'anesthetized but cannot-ventilate' situation.

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References

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"Poor Man's LMA"

To the Editor:
Boyce[1] states that his patient "preferred to keep his full beard intact on religious grounds", but it appears that this was a hasty solution to an unexpectedly difficult mask airway.

Most disturbing was the scant disregard for caution in managing this patient's anesthetic induction. A morbidly obese, edentulous gentleman with a full beard and obstructive symptoms during sleep should set off alarm signals. Yet anesthesia was induced with thiopentone, fentanyl and rocuronium without ensuring the ability to maintain the airway or ventilate with a mask prior to inducing apnea.

To then rationalize the extra time available to intubate by the use of intermediate-acting depolarizing agents "where laryngoscopy or intubation are predicted to be challenging" is risky without having assessed the ability to ventilate by mask.

The 'Poor Man's LMA' brings to mind two potentially lethal consequences of placing a tube in the oropharynx and ventilating the lungs and, probably, the stomach. Gastric insufflation was a major hazard here with its attendant risks of pulmonary aspiration and gastric rupture. Strategies to improve the mask seal in