LMA in patients with laryngeal pathology and, in particular, laryngomalacia. Whilst the LMA may not be the preferred form of airway management for diagnostic laryngoscopy, it may still prove useful in both the management and diagnosis of laryngeal pathology. This was recently illustrated by Smith, Whittet and Heyworth, who reported a 5-month-old infant undergoing diagnostic laryngobronchoscopy for intermittent stridor [2]. During gaseous induction, stridor worsened considerably and the oxygen saturation decreased. A steady state of light anaesthesia was reached, but with an oxygen saturation of 75-80%. A size 2 LMA was inserted easily and a clear airway obtained. A fibreoptic scope was subsequently passed down the LMA and the classical features of laryngomalacia demonstrated. On the basis of this, it was felt that the LMA may be of specific value in laryngomalacia. The successful use of the LMA in tracheal stenosis has also been reported in a child in whom it provided an adequate airway without traumatizing the trachea or increasing airway resistance [3].

Children with laryngotracheal pathology require meticulous airway management which is best performed by experienced paediatric anaesthetists. Although it is possible that the LMA might worsen some forms of laryngeal pathology, we feel that the LMA may prove useful in some patients, particularly those in whom other forms of airway management have failed. As with many other areas of LMA usage in paediatric practice, further studies are required to help define its role. Meanwhile, we would recommend that the LMA is available when anaesthetizing children with laryngotracheal pathology.

J. BRIMACOMBE
A. BERRY
Royal Perth Hospital
Perth, Australia


Sir,—My caution was directed mainly at the use of the LMA for diagnosis, rather than management of patients with laryngeal pathology. A correctly sited LMA does not permit inspection of the epiglottis with a fibrescope.

The management of the patient described by Smith, Whittet and Heyworth [1] was obviously helped by use of the LMA. This may or may not have been a result of a specific effect of the LMA on lax supraglottic structures. One should not conclude that the LMA is especially helpful in the management of patients with laryngomalacia on the basis of one case report.

I reiterate my comments about insertion technique. Insertion of an LMA with air in the cuff, or carelessly performed, may readily downfold an abnormal epiglottis. This hypothesis is reinforced by a recent paper from Brimacombe and Berry [2] in which they compared insertion techniques in adults. Briefly, they found the epiglottis to be visible fibreoptically more often when the cuff was partially or fully inflated on insertion than when the recommended technique was used. I urge trainees to read their paper and to learn the technique described in detail in the manufacturer’s instruction manual.

I agree that the LMA should be available during the management of children with difficult airways.

I. G. WILSON
St James’s University Hospital
Leeds