THE LARYNGEAL MASK FOR INTRAOCULAR SURGERY

Sir,—Ripart, Cohendy and Eledjam [1], in commenting upon the article by Lamb, James and Janicki [2], described two untoward incidents associated with the use of the laryngeal mask airway (LMA) for controlled ventilation during intraocular surgery. As a result, they have abandoned the technique. They have done so without relating the incidents to their total experience of the LMA and without quantifying the complications associated with tracheal intubation.

Our own clinical experience of LMA use with controlled ventilation in intraocular surgery during the past 2 years supports the original contentions of Lamb, James and Janicki [2]. Our audit data show that, in 593 uses, there were six difficult placements (five were eventually successful, while in the sixth the trachea was subsequently intubated); one LMA became displaced during the procedure but was repositioned quickly and successfully and there was one case of gastric distension because of misplacement which was corrected before surgery commenced. Only the last two incidents presented a significant clinical problem (0.3% of the total use). Neither resulted in morbidity. Over the same period this compared with a 1.6% incidence of serious problems with the use of tracheal tubes (three of 187 uses): one case of laryngeal spasm, one difficult intubation and one episode of pulmonary oedema at extubation.

For all our surgical specialties, 135 incidents were reported in 3974 tracheal intubations (3.4%): 120 difficult placements and 15 episodes of laryngeal spasm. There were 52 incidents in 5655 LMA uses (0.9%): 45 difficult placements and seven episodes of laryngeal spasm (chi-square = 73.93; P < 0.001).

With sufficient experience, use of the LMA can provide improved operating conditions for intraocular surgery and a smooth recovery with a small incidence of serious problems. Contrary to the anecdotal comments of Ripart, Cohendy and Eledjam, our data support use of the LMA for controlled ventilation in intraocular surgery.

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Sir,—I read with interest the article of Van Elstraete and colleagues on tracheal tube cuff inflation as an aid to blind nasotracheal intubation [1]. Ilation of the tracheal cuff in the oropharynx is assumed to centre the tip of the tube and to direct it anteriorly towards the larynx. The authors showed a high success rate when the technique was used in anaesthetized and paralysed patients with a normal airway, whose head and neck can be manipulated safely to place the head in the "sniffing" position before tracheal intubation. However, it remains to be established if the technique improves the success rate of blind nasotracheal intubation in cases of difficult intubation.

I have recently tried the technique for awake blind nasotracheal intubation in a 26-yr-old male patient who suffered cervical spine fracture. The spinal cord was intact and the patient was brought to the operating room in traction for cervical spine fixation. Traction or manual in-line stabilization, although reducing cervical spine movement, places the oral, pharyngeal and laryngeal axes out of alignment and makes orotracheal intubation more difficult, therefore, it was planned to proceed with awake blind nasotracheal intubation [1]. Inflation of the tracheal cuff in the oropharynx was aimed to centre the tip of the tube and to direct it anteriorly towards the larynx. The authors showed a high success rate when the technique was used in anaesthetized and paralysed patients with a normal airway, whose head and neck can be manipulated safely to place the head in the "sniffing" position before tracheal intubation. However, it remains to be established if the technique improves the success rate of blind nasotracheal intubation in cases of difficult intubation.

The procedure was abandoned, and it was decided to try tracheal tube cuff inflation as an aid to blind nasotracheal intubation. The cuff of the tube was inflated, blind tracheal intubation was attempted. However, three attempts failed to achieve intubation. The procedure was abandoned, and it was decided to try tracheal tube cuff inflation as an aid to blind nasotracheal intubation. The cuff of the tube was inflated in the oropharynx with 20 ml of air, and the tube was advanced gently while the patient was breathing spontaneously. Slight resistance was felt, while free air movement continued through the tube, denoting entry of the tip of the tube into the glottis and contact of its inflated cuff with the vocal cords. At that time, the cuff was deflated, the tracheal tube was advanced into the trachea and the cuff was reinflated.

This experience demonstrated that the cuff inflation technique can facilitate awake blind nasotracheal intubation in cases of cervical spine injury which may not allow or may even contraindicate manipulation of the head and neck to achieve the "sniffing" position.

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Sir,—We agree that this technique may be of use in such patients. Although patients in our study were anaesthetized and paralysed...