Correspondence

Editor—We are grateful to Drs McBrien, Breslin, and Webb for their interest in our Editorial, and congratulate them on their successful management of a difficult clinical problem. Their patient probably suffered an anaphylactic reaction to protamine, although no details of skin testing or the allergist’s opinion are provided. Phenylephrine was used in resuscitation, before and after a single bolus of epinephrine.

Clearly, instances arise when a selective &-adrenergic agonist might be used preferentially to non-selective epinephrine; in their somewhat unusual case, &-adrenergic effects were unnecessary, as the heart could be seen contracting vigorously. †-Agonists may indeed have been harmful to the recently revascularized myocardium.

The Association Guidelines do state that, in some patients, an alternative catecholamine may be required, although this appears in the text of the document and not in the ‘model operating procedure’ in Appendix 2; indeed, we have incorporated this into our own departmental guideline. We believe that the Association Guidelines are correct to emphasize the timely use of epinephrine in appropriate, and, where necessary, repeated doses. This represents, in the majority of cases, and especially for our trainees, safe and effective practice; frequently, &-adrenergic effects are required, especially where there is bronchospasm. We do not question the use of an &-adrenergic agonist on the rare occasion that epinephrine is ineffective, but would reinforce the most important message in treating anaphylactic reactions: that epinephrine be given immediately, and usually in repeated doses.

On a practical note, it seems difficult to produce a guideline, which may be extant for some years, incorporating drugs which are then withdrawn (methoxamine), or become sporadically unavailable (phenylephrine). One must remember also that, since its regular use in anaphylaxis began in the 1970s, epinephrine has saved countless lives.

In our Editorial, we had hoped to illustrate issues relating to the diagnosis and investigation of anaphylactic reactions during anaesthesia, and in particular the patchy and uncoordinated reporting of such reactions in the UK, when many of our Australasian, French, and Scandinavian colleagues have in place excellent systems. To perform a clinical trial comparing the effectiveness of different vasopressors in anaphylaxis will never be possible. However, one might speculate that, if a national database were established, more a rational analysis of drugs used in anaphylactic reactions might be performed. We eagerly await this development.

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CobraPLA as a conduit for flexible bronchoscopy in a child under general anaesthesia

Editor—A 2-yr-old, 17 kg girl presented with episodes of cough and stridor. The chest X-ray was negative. No other significant medical history was reported. A possible diagnosis of foreign body aspiration was made and a bronchoscopy under general anaesthesia was planned.

Anaesthesia was induced with sevoflurane in oxygen 100%, i.v. access was established and a size 2 LMA® was inserted without difficulty. Ventilation was easy, with a leak pressure of 17 cm H2O. A paediatric bronchoscope was introduced through the LMA while the patient was breathing spontaneously isoflurane 1.5% in oxygen 100% but the vocal cords could not be visualized—score 1 on the Brimacombe scale. The LMA was removed and reinserted, ventilation was satisfactory, but vocal cord visualization failed again. At this stage a CobraPLA size 1.5 was inserted without difficulties, ventilation was easy with a leak pressure of 28 cm H2O. The bronchoscope was introduced through the CobraPLA, the cords visualized (score 4 on the Brimacombe scale) and advanced into the larynx. No foreign body was found. The isoflurane was discontinued, the CobraPLA was removed and the patient recovered without complications.

CobraPLA (Engineered Medical System, Indianapolis, IN, USA) is a new supraglottic device that may have some advantages over the LMA: (i) it may be easier to insert than the LMA with no need for any airway manipulation; 3 4 (ii) it may be more stable owing to the CobraPLA’s ‘head’, which lies on the posterior pharynx and does not allow rotation; (iii) it has a good airway seal, permitting use of higher airway pressure in case positive pressure ventilation is necessary; 5 and (iv) larger tube diameter and shorter tube length than the LMA permitting positioning of a larger endotracheal tube. 3

An LMA is a safe and effective adjunct to fibreoptic bronchoscopy under general anaesthesia in children. 4 In one study, 3 appropriate positioning, as judged by fibreoptic laryngoscopy, was achieved in 49% of patients. CobraPLA was compared with the LMA and PAXexpress in adult patients, and proved to have a more effective seal and a better fibreoptic score. 5 In adults, Akça and colleagues’ 7 found both LMA and PLA gave an equally good laryngeal view. In children, the there are no comparative data available and conclusions cannot be drawn from a single case.

* LMA® is the property of Intavent Limited.
Nevertheless, with the new supraglottic devices on the market, anaesthesiologists have another option available.

In conclusion, CobraPLA can be used as an alternative to LMA for flexible bronchoscopy in children under general anaesthesia.

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