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Letters to the editor

Tracheal intubation through the laryngeal mask

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To the editor:

I read with interest the report of tracheal intubation through the laryngeal mask in an anesthetized patient with restricted mouth opening [1]. I feel that in patients with difficult airways, this technique is used more safely when patients are awake.

Placement of the laryngeal mask may be difficult, if not impossible, when mouth opening is restricted. Dr. Kawaguchi and colleagues claim that it is not difficult to place the mask in the correct position if the mask passes through the mouth, because the anatomy of the pharynx is usually normal. The success rate of anatomically correct placement, however, is decreased if the mask is not driven fully into the hypopharynx by the index finger (as recommended by the manufacturer's Instruction Manual), although adequate ventilation may often be obtained [2]. The success rate of tracheal intubation through the laryngeal mask may thus be lower than usual in patients with restricted mouth opening.

I described a technique of awake fiberscope-aided tracheal intubation through the laryngeal mask [3]. When patients are awake, there is little danger of loss of a patent airway even if placement fails. Dr. Kawaguchi and colleagues claim that fiberscope-aided tracheal intubation is uncomfortable or stressful for awake patients [1]. I feel that placement of the mask and subsequent tracheal intubation through the mask are not stressful and are usually acceptable for awake patients when local anesthetics and sedatives are given properly [3]. Others also report that placement of the laryngeal mask is not stressful for awake patients [4]. Anesthesia might be induced after placement of the mask and before tracheal intubation to reduce stress to patients [3], although there is a danger of loss of a patent airway if tracheal intubation fails. Awake tracheal intubation through the laryngeal mask may be used in patients at increased risk of pulmonary aspiration, since airway reflexes are not lost [3]. In their case, the patient might have been at greater risk of pulmonary aspiration, because the patient had a history of neurological disease. I, therefore, suggest that in patients with difficult airways who are at increased risk of pulmonary aspiration, awake tracheal intubation, including awake intubation through the laryngeal mask, is safer.

There is a factor that we should bear in mind when a tracheal tube is passed through the laryngeal mask. I stated that when a 6.0-mm tracheal tube is passed through the laryngeal mask and the mask is left in place, the cuff of the tracheal tube would often lie between the vocal cords [3]. I later confirmed this and have offered several methods to avoid this complication [2,5].

References

1. Kawaguchi M, Sakamoto T, Ohnishi H, Takaoka M, Karasawa J (1994) Airway management in a patient with pseudoankylosis of the mandible following frontotemporal craniotomy. J Anesth 8:346–348
2. Asai T, Morris S (1994) The laryngeal mask airway: its features, effects and role. Can J Anaesth 41:930–960
3. Asai T (1992) Use of the laryngeal mask for tracheal intubation in patients at increased risk of aspiration of gastric contents. Anesthesiology 77:1029–1030
4. Brimacombe J, Newell S, Swainston R, Thompson J (1992) A potential new technique for awake fibreoptic diagnostic bronchoscopy: use of the laryngeal mask airway. Med J Aust 156:876–877
5. Asai T, Latto IP, Vaughan RS (1993) The distance between the grille of the laryngeal mask airway and the vocal cords: is conventional intubation through the laryngeal mask safe? Anaesthesia 48: 667–669

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