CORRESPONDENCE

Anesthesiology
78:995, 1993
© 1993 American Society of Anesthesiologists, Inc.
J. B. Lippincott Company, Philadelphia

In Reply—Maltby and Neil agree that "scientific proof" should form the basis for the indications and contraindications of the laryngeal mask airway (LMA). If, however, Maltby and Neil base their views of the efficacy of the LMA on "several case reports as well as the manufacturer's instructional videotape," then clearly we disagree as to the proper definition of "scientific proof." Certainly, the manufacturer’s instructional videotape can be expected to be at least somewhat biased, and the fallacy in relying on a few complication-free/side effect-free case reports to accurately predict future events has been well explained by Rumke and Hanley and Hand. Furthermore, we know that the LMA may be wholly inadequate in as many as 6% of anatomically normal patients. Keeping this known LMA failure rate in mind, the danger of relying on the LMA to provide gas exchange in an anesthetized paralyzed patient whose trachea cannot be intubated conventionally is obvious. Maltby and Neil have spotlighted the problem with much of the current literature on the LMA: i.e., anecdotal testimony in letters to the editor, case reports, and very small clinical series, but no one is going to be able to prove their hypotheses in the absence of properly controlled scientific studies.

Jonathan L. Benumof, M.D.
Professor of Anesthesia
Department of Anesthesiology
University of California, San Diego Medical Center
200 West Arbor Drive
San Diego, California 92108-8812

References
(Accepted for publication February 15, 1993.)

Left Bronchial Intubation by the Laryngectomy Tube

To the Editor—Because of the anatomy of the tracheobronchial tree, it has been suggested that an endotracheal tube can be introduced more readily into the wider and more vertically oriented right main bronchus than into the narrow and more obliquely oriented left main bronchus. However, Baraka et al. subsequently showed that the bevel of the endotracheal tube, and not the tracheobronchial angle, is the principal factor determining the side of intubation. With the bevel of the tracheal tube on the left side, its tip is positioned to the right of the tracheal axis, which favors advancement of the tube to the right main bronchus.

In contrast to the left-bevelled tracheal tubes, tracheostomy tubes usually have no bevel, and laryngectomy tubes are designed to have their bevel anterior; hence, the tracheostomy tube or the laryngectomy tube may be advanced either to the right or to the left main bronchus, as shown by the present case report.

In a 61-year-old woman with a laryngeal tumor, tracheostomy was performed between the second and third tracheal rings. After insertion of a Mallinckrodt laryngectomy tube with inside diameter 8 mmHg, resistance to ventilation was observed and pulse oximetry showed a decrease of oxygen hemoglobin saturation to 70% despite ventilation with 100% oxygen. Chest auscultation showed that breath sounds were greater on the left than the right side. Chest x-ray confirmed left bronchial intubation, and the laryngectomy tube was withdrawn until equal breath sounds were auscultated on both sides of the chest.

The report confirms our previous finding that the bevel of the endotracheal tube, and not the tracheobronchial angle, is an important factor determining the side of inadvertent bronchial intubation. The anesthesiologist must be aware that a tracheostomy tube and a laryngectomy tube with no lateral bevel have an equal chance of advancement to the right or the left main bronchus.

Anis Baraka, M.D.
Samar Jabbour, M.D.
Paula Rizkallah, M.D.
Department of Anesthesiology
American University of Beirut
Beirut, Lebanon

References
(Accepted for publication February 22, 1993.)