

## ■ CORRESPONDENCE

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### Laryngeal Mask Airway and Pulmonary Edema: I

*To the Editor:*—A recent report by Ezri *et al.*<sup>1</sup> describing two patients who developed airway obstruction and pulmonary edema after insertion of the laryngeal mask airway (LMA) raises some important points regarding its use.

In both cases, difficulties were encountered on inserting the LMA. We are not informed which aspect of insertion was difficult. Usually negotiating the posterior pharyngeal curve has proved most difficult. We would like to suggest a number of maneuvers that may be helpful in this situation. These include a rotational movement of the tube,<sup>2</sup> slight inflation of the cuff,<sup>3</sup> a jaw thrust maneuver,<sup>4</sup> or rarely, use of a laryngoscope.<sup>5</sup>

Repeated attempts at inserting an LMA must not be made at the expense of adequate ventilation and oxygenation. If necessary, an oral airway should be inserted and the patient's lungs ventilated *via* a face mask between attempts.

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### Laryngeal Mask Airway and Pulmonary Edema: II

*To the Editor:*—Ezri *et al.*<sup>1</sup> describe two cases of pulmonary edema due to upper airway respiratory obstruction associated with the laryngeal mask airway (LMA). In the patients documented, this complication was probably due to poor insertion technique, because the airway was ultimately successfully maintained in both cases with the aid of the LMA.

The onset of pulmonary edema following upper airway respiratory obstruction is not a new phenomenon.<sup>2</sup> The two cases cited in this letter purport to indict the LMA as the cause of airway obstruction-related pulmonary edema, but a number of points should be borne in mind. First, the study from our hospital<sup>3</sup> quoted the incidence of problematic insertion of the LMA as being between 2% and 3.6%, in marked contrast to the 10% incidence quoted by the authors from a much smaller study.<sup>4</sup> In our hands, the incidence of laryngospasm is minimized by the use of propofol as the induction agent. Second, it would be interesting to know what mode of induction was employed by the authors in these cases and for how long upper airway obstruction persisted prior to the onset of pulmonary edema.

Ultimately it was the upper respiratory airway obstruction that

caused pulmonary edema in these patients and not the LMA. We believe that the LMA is an excellent adjunct to the maintenance of the patency of the upper airway, loss of which may result in the very problem blamed on the device by the authors of this letter.

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