

CORRESPONDENCE

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In Reply:—I appreciate the interest of Butler and Kenny in our method of preoxygenation.¹ We did not intend to imply that this method alone would achieve an optimal alveolar oxygen fraction. However, in patients who refuse placement of a mask on their face, the method we describe is superior to no preoxygenation.

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Placement of an Endotracheal Device *Via* the Laryngeal Mask Airway in a Patient with Tracheal Stenosis

To the Editor:—Treatment of tracheal stenosis by means of the insertion of endotracheal prosthesis¹ through the endotracheal tube (ETT) is difficult. A patient with tracheal stenosis in whom laryngeal mask airway (LMA) was successfully used to place a metal-stent prosthesis is reported.

A 39-yr-old woman, height 156 cm, weight 56 kg, with idiopathic subglottic tracheal stenosis and vocal cords synechia underwent several surgical interventions with immediate but short-term clinical improvement. An expandable metal tracheal stent was inserted *via* an ETT (size 7.5, Mallinckrodt) and fluoroscopic monitoring under general anesthesia, but a computed tomographic scan revealed distal displacement 48 h after the insertion, producing increased respiratory symptoms. A second endoprosthesis was inserted, this time *via* an LMA (fig. 1). After preoxygenation, anesthesia was induced with propofol (2.5 mg/kg) and fentanyl (20 mg), and a size 4 LMA was inserted. Anesthesia was maintained with a mixture of 50% air/oxygen and an infusion of propofol (0.16–0.11 mg · kg⁻¹ · min⁻¹). The extent of the stenosis was evaluated using direct visualization through a flexible fiberoptic scope (Olympus LF-1, Tokyo, Japan) aided by fluoroscopic monitoring; radioopaque marks were drawn on the neck at the level of the superior and inferior borders of the stenosis. The leader catheter of the stent was introduced through the LMA and was directed to the stenosed area by direct visualization aligned with the radioopaque skin markers. Once in position, the stent was advanced to the stenotic area, and the leader was withdrawn. To facilitate the handling of the instruments, the aperture bars of the LMA were removed before its positioning.

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Reference

1. Keifer RB, Stirt JA: Preoxygenation (letter). *ANESTHESIOLOGY* 1995; 83:429

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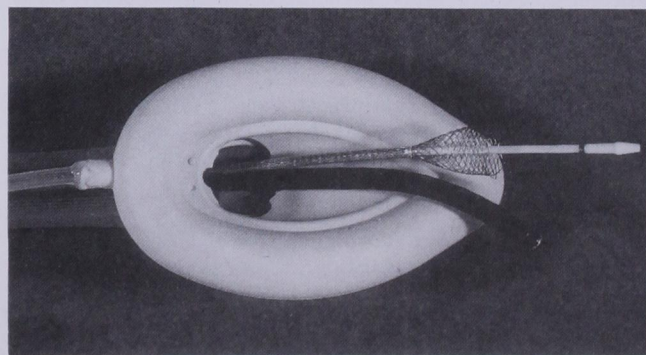


Fig. 1. Prosthesis and fiberoptic scope through laryngeal mask airway.

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