unit as whole blood rather than as two separate entities, although this results in some decrease in concentration of coagulation factors V and VIII. Separated, frozen plasma and erythrocytes should be made available on request for donor-designated and autologous units.

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Intubation through a Laryngeal Mask Airway with a Nasal RAE Tube: Stabilization of the Proximal End of the Tube

To the Editor:—Use of the laryngeal mask airway (LMA) as a conduit for tracheal intubation with a fiberoptic bronchoscope and endotracheal tube (ETT) in multiple clinical circumstances was described recently.[1] When a standard 28- to 29-cm long 6.0-mm internal diameter (ID) ETT is advanced distally as far as possible (ETT and LMA adaptors in physical contact with one another), the cuff of the ETT, at a maximum, will be subglottic by only 1-2 cm; the cuff of a standard ETT may locate between the vocal cords. A solution to this problem is to use a 34- to 35-cm long nasal RAE tube, which is long enough to allow placement of the tip and cuff of the tube in the mid-trachea.[2,3] We have noted that when the tip and cuff of the 6.0-mm ID nasal RAE tube is optimally placed (mid-trachea) in some patients, 2-5 cm of the ETT protrudes from the proximal end of the LMA adaptor. The LMA adaptor then acts as a fulcrum, around which the protruding 2-5 cm length of proximal ETT may kink (fig. 1A).

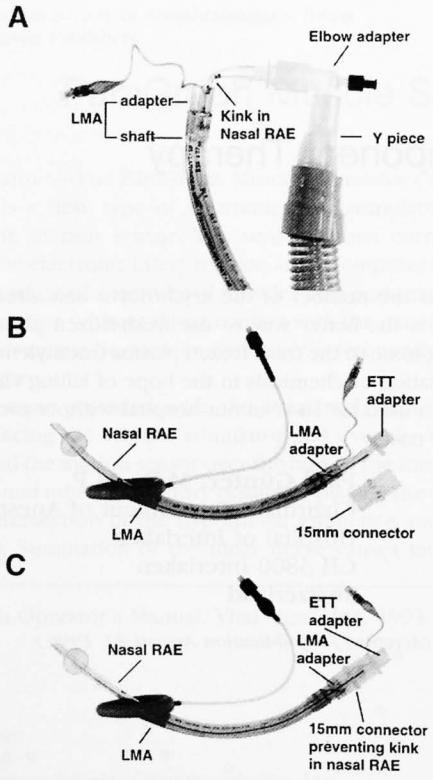

Fig. 1. (*A*) 6.0-mm internal diameter (ID) nasal RAE tube placed inside #3 laryngeal mask airway (LMA) and connected to an anesthesia circle system. The adaptor of the LMA acts a fulcrum, around which the nasal RAE tube may kink. (*B*) A 6.0-mm ID nasal RAE tube placed inside a #3 LMA. Next to the protruding length of nasal RAE tube is a free-standing 15-mm ID male-to-male anesthesia circle system hosing connector. (*C*) The 15-mm ID anesthesia circle system hosing connector is placed on the LMA adaptor, to provide a stable, nonkinkable conduit for the protruding length of nasal RAE tube.

We propose a simple solution to stabilize the proximal end of the protruding nasal RAE tube. A standard 15-mm ID, male-to-male anesthesia circle hosing adaptor (#H-1194, Hull Anesthesia) fits the proximal end of the LMA adapter and provides a stable conduit/stent for the short length of proximal protruding nasal RAE tube (figs. 1B and 1C). We have not encountered any problems in using this method to stablize the proximal end of the nasal RAE tube. We hope this adaptor, which should be readily available in anesthesia storerooms, is of use to others when using LMAs, fiberoptic bronchoscopes, and nasal RAE tubes for difficult airway management.

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