A Thyroid Shield Can Correct a Laryngeal Mask Airway Air Leak

To the Editor.—A patient was anesthetized for an orthopedic procedure and a no. 4 laryngeal mask airway (LMA) was inserted. An air leak around the LMA was observed at approximately 12 cm H₂O pressure, causing ventilation to be inadequate. I attempted to alleviate the air leak by repositioning the LMA, changing the cuff inflation volume, and repositioning the patient’s head, with no success. Accordingly, I prepared to exchange the LMA with an endotracheal tube when the circulating nurse placed a thyroid shield on the patient in preparation for fluoroscopy. The air leak ceased and the case was completed using the LMA.

On several subsequent occasions, I have successfully used a thyroid shield to ameliorate an air leak around an LMA. The patient shown in figure 1 is such an example. The patient had a no. 4 LMA inserted without difficulty, but despite multiple manipulations of the LMA, LMA cuff, and the patient’s head, the LMA had a persistent leak at 10–12 cm H₂O. The patient was breathing spontaneously but entraining room air around the LMA cuff. Placement of a thyroid shield allowed positive pressure ventilation up to 22 cm H₂O, and the room-air entrainment stopped with spontaneous ventilation. To date, I have had no instances of failure to correct an LMA cuff leak and was able to proceed with the anesthetics planned using an LMA.

The mechanism for this result seems to be that the thyroid shield forces the soft tissue of the anterior pharynx against the LMA cuff. LMA cuff pressure is adjusted to maintain an air leak around the LMA of 20–25 cm H₂O to lessen the risk of pharyngeal mucosal ischemia.

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Caution in Performing Epidural Injections in Patients on Several Antiplatelet Drugs

To the Editor.—We wish to alert our colleagues about the danger of performing epidural injections in patients who are receiving several antiplatelet drugs. A patient with acute onset of quadriplegia was referred to our hospital with a large cervical epidural hematoma. He developed numbness and weakness of his arms and legs within 30 min after the performance of a cervical epidural steroid injection. At the time of injection, he was taking several antiplatelet drugs (diclofenac, clopidogrel, and possibly aspirin) that had been started after a prior coronary angioplasty. He had a prior uneventful cervical epidural steroid injection 11 days before the incident in question, but it is not clear if he was taking these antiplatelet drugs then. The patient had no history of easy bruising. His prothrombin time, international normalized ratio, and partial thromboplastin time were within normal limits, and his platelet count was 160,000/µl but the timing of the last doses of antiplatelet drugs was unclear. He underwent an emergency C3–T5 laminectomy and evacuation of cervical epidural hematoma, which extended from the C2 to C7 vertebral levels, approximately 14 h after the epidural injection. Postoperatively, the strength in the patient’s upper extremities improved, but his lower extremities remained paralyzed. Three months after surgery, he had regained his strength in his upper extremities, but the paralysis of his lower extremities remained.

The relative safety of epidural injections in patients on antiplatelet drugs has been established. In the rare case reports of spina...