of surgery may encourage this sequence of events and is therefore not appropriate when using the LMA. There have been three reports of LMA-related aspiration associated with light anaesthesia [7–9]. If regurgitated fluid is seen emerging from the LMA tube in a technically fasted patient, I would suggest that the patient should be placed in a Trendelenburg position of at least 30°, anaesthesia deepened and the circuit temporarily disconnected to allow free drainage of the fluid from the LMA. It is unwise to remove the LMA in order to intubate the patient’s trachea at this stage, because LMA removal is liable to encourage aspiration. Premature deflation, removal, or both, of the LMA when reflexes are partially restored is the likely cause of aspiration, according to Griffin and Hatcher [10]. The correctly placed LMA tube does not prevent this regurgitant fluid completely, but is likely to act like a ball-valve against the upper oesophageal sphincter as long as it remains inflated and positioned correctly. There is evidence that LMA placement is optimal when using the standard insertion technique [11].

Poor patient selection has been responsible for previous incidences of aspiration associated with the LMA [7, 11–13]. The overall incidence of aspiration with the LMA would appear comparable in outpatient anaesthesia with either face mask or tracheal tube [14]. Safe use of the LMA with positive pressure ventilation requires not only exclusion of any patient at risk of regurgitation, but provision of adequate anaesthesia and neuromuscular block together with the use of tidal volumes of 8 ml kg⁻¹ and low inspiratory flow rates to ensure peak airway pressure remains as low as possible and certainly does not exceed 25 cm H₂O. The use of a stethoscope taped to the side of the neck allows detection of anesthetic gas leakage. In our opinion, and according to procedures for failed intubation [2], it seems unwise to anaesthetize a patient known to already compromise (airway distortion, limited opening of the mouth) and therefore we consider that safer approaches to ventilation require not only exclusion of any patient at risk of regurgitation, but provision of adequate anaesthesia and neuromuscular block together with the use of tidal volumes of 8 ml kg⁻¹ and low inspiratory flow rates to ensure peak airway pressure remains as low as possible and certainly does not exceed 25 cm H₂O. The use of a stethoscope taped to the side of the neck allows early detection of mask leaks which, in combination with an increase in inflation pressure, serve to alert the anaesthetist to the need for prompt remedial action before the events leading to regurgitation are set in train.

A. I. J. BRAIN
Northwick Park Hospital
Harrow, Middlesex


Sir,—Many anaesthetists would consider the laryngeal mask airway (LMA) as one of the most significant innovations in anaesthetic equipment in recent years. Falling somewhere between a face mask and a tracheal tube, it provides an airway which is, in the vast majority of instances, superior to that associated with the former but is unquestionably less secure than that provided by the latter.

The LMA must be regarded as a device to be used only in patients breathing spontaneously. It can never be expected to provide the same degree of protection afforded by a cuffed tracheal tube. The LMA must never be regarded as a routine alternative to a tracheal tube in patients whose anaesthetic technique involves the use of intermittent positive pressure ventilation (IPPV). To elect to ventilate the lungs of a patient via the LMA during an anaesthetic associated with the use of non-depolarizing blockers when tracheal intubation would otherwise have been possible, is to my mind to fall short of good anaesthetic practice. Such failure to comply with established safe routines subjects patients to an increased risk of aspiration; use of the LMA in these circumstances represents an abuse of an otherwise splendid and ingenious piece of anaesthetic equipment. There are of course those times when we have been thankful for a gadget through which we are able to ventilate lungs of a paralysed patient, where intubation is proving to be hazardous or even impossible. For this the anaesthetic specialty will always be grateful and lives will be saved. Lives, however, may well be lost if we abandon the use of a tracheal tube when undertaking IPPV of the lungs.

J. W. CROOKE
Royal Liverpool University Hospital Trust

Alfentanil and propofol for difficult intubation?

Sir,—We congratulate P. F. McDonald on the successful management of a patient with a difficult airway using propofol and alfentanil [1]. Nevertheless, this unusual approach to the management of such a life threatening situation raises some questions. After an unsuccessful fibreoptic intubation attempt while the anaesthetist was unable to ventilate the lungs, he decided to administer propofol and alfentanil in order to facilitate mouth opening. In our opinion, and according to procedures for failed intubation [2], it seems unwise to anaesthetize a patient known to present a possible difficult intubation whose lungs cannot be ventilated. Instead, blind nasal intubation or cricothyrotomy might be safer alternatives. We recently encountered a very similar case and we were able to intubate the lungs using blind nasotracheal intubation facilitated by inflating the tube cuff with 15 ml of air, according to the technique described by Coghlan, McDonald and Caspargi [3].

Propofol and alfentanil have been used successfully for nasotracheal intubation in elective maxillofacial procedures. Nevertheless, in the case presented by McDonald the airway was already compromised (airway distortion, limited opening of the mouth) and therefore we consider that safer approaches to intubation should be used in such situations.

T. EZRI
D. SZMUR
Department of Anaesthesia
Kaplan Hospital
Rehovot, Israel