

## Letters to the editor

### Laryngeal mask airway in ENT surgery

Dear Sir,

I read with keen interest the article 'The laryngeal mask airway in ENT surgery' by R. E. Daum and B. J. O'Reilly (*Journal of Laryngology and Otology*, 1992; **106**: 28–30). They concluded from their work that they would advocate the introduction of laryngeal masks to improve safety and speed as well as to economize.

The use of laryngeal masks is not without its problems. In a prospective study of 122 routine adult ENT surgical procedures (excluding tonsillectomies and palatal surgery), laryngeal masks were used in eight cases, there was injury to the soft palate/uvula in two cases (awaiting publication). In one case a catgut stitch had to be inserted into the soft palate at the base of the uvula. Both these two patients had to remain in hospital for a further two days for adequate pain relief. There has been at least one other case report of injury to the uvula due to improper use of a laryngeal mask.

Great care has to be taken with the use of laryngeal masks in ENT surgery, but in experienced hands I am sure they are safe, quick and economical.

Yours faithfully,  
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### Reply:

Dear Sir,

We were most interested to hear of the problems encountered by Mr Connolly in two of the eight cases in which the laryngeal mask airway (LMA) was used in this study. In all new techniques there is a learning curve and we ensured that our junior anaesthetists were carefully instructed and then supervised when they first used the LMA. Usually the insertion of the LMA is straightforward and atraumatic. On the rare occasion when it proves difficult to position the LMA, it should not be forced against the patient's soft palate but manoeuvred into position by a gloved finger. Most of the 217 cases we reported had their LMA inserted by unsupervised juniors and no patient suffered an injury to the soft palate or uvula.

Experience of the LMA in this hospital is now quite extensive with nearly 2000 cases throughout all specialities; none of these patients has required an extended inpatient stay because of injuries sustained from insertion of a LMA. Indeed, in the experience of ourselves and others (Jensen *et al.*, 1982; Brain *et al.*, 1985; Broderick *et al.*, 1989) sore throats are much less common after LMA insertion than after endotracheal intubation.

Yours faithfully,

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### References

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### Emergency cricothyroidotomy

Dear Sir,

I read with interest the Review Article on emergency cricothyroidotomy by Milner and Bennett (1991). Further inspection of the literature shows that there is still controversy concerning this technique.

Kuriloff *et al.* (1989) found a 52 per cent incidence of airway complications in 31 surviving patients treated by elective cricothyroidotomy. Subglottic stenosis accounted for 50 per cent of these. Frei *et al.* (1990) reported a high rate (18 per cent) of damage to the laryngeal cartilages using the 'Quick Trach' method in 55 cadavers. In their prospective study Holst *et al.* (1990) showed that only 10 out of 19 patients tested after cricothyroidotomy were found to have normal voices.

As an alternative, tracheostomy seems to have fewer drawbacks, even in children (Freezer *et al.*, 1990). (Waldron *et al.* (1990) noted that in a series of 150 consecutive tracheostomies in adults, no cases of symptomatic stenosis occurred. They stated that recent moves away from tracheostomy should only continue if the alternatives prove to have an even lower complication rate.

In their paper, Esses and Jafek (1987) recommend rapid conversion from a cricothyroidotomy to a standard tracheostomy if the need for airway control is likely to be prolonged. They also state, as do Kuriloff *et al.* (1990), that cricothyroidotomy is not to be recommended in the presence of laryngeal inflammation or infection. This argument is supported by Cole and Aguilar (1988) who felt that laryngeal pathology of any kind was an absolute contraindication to cricothyroidotomy if complications were to be avoided.