

Letter to the Editors

The reinforced laryngeal mask in dental day surgery

We read with interest the paper by Goodwin et al. (*Ambulatory Surgery* 1993; 1: 31–35) which compared the reinforced laryngeal mask airway (RLMA) with nasotracheal intubation (NTI) for dental day surgery. Whilst concurring with the authors that the RLMA provides a reliable method of airway management for removal of impacted wisdom teeth, we feel that if total intravenous anaesthesia (TIVA) had been employed for both groups, a more useful comparison of the two techniques would have been possible. The NTI technique involved the use of suxamethonium followed by inhalational anaesthesia; whereas TIVA with propofol was used in the RLMA group. The statistically significant differences between the two groups were that recovery times were longer and there was a greater incidence of myalgia with the NTI group. It would seem likely that these differences were due to the use of a volatile agent and suxamethonium rather than the choice of airway, and a short-acting non-depolarizing agent followed by TIVA may have produced different results. Interestingly, the study does demonstrate a higher incidence of technical anaesthetic difficulty with NTI when compared with the RLMA (26% vs. 14%), and also a significantly higher incidence of postoperative bleeding.

In addition we would like to make two further points.

The reinforced laryngeal mask airway is not made from latex, but silicone tubing reinforced with wire. Finally, Figure 1b, whilst illustrating that the RLMA is kink-proof probably overemphasizes the ease with which a conventional LMA can be occluded. Kinking was a problem in an early production model of the size 2 LMA¹ and this has since been corrected by the manufacturer². It is important that a kink test is performed prior to insertion of a conventional LMA by bending the tubing upon itself to 180°, as any kinking will imply a defective LMA, probably from overuse, which should then be discarded. Bending the tube beyond 180° will, however, produce a 'remembered' kink and should be avoided.

References

- 1 Rowbottom SJ, Simpson DL, Grubb D. The laryngeal mask airway in children. A fiberoptic assessment of positioning. *Anaesthesia* 1991; **46**: 489–91
- 2 Goldberg PL, Evans PF, Filshie J, Martin DW. Kinking of the laryngeal mask airway in two children. *Anaesthesia* 1990; **45**: 487–8

J Brimacombe MB ChB FRCA*

A Berry MB ChB FRCA

Dept. Anaesthesia and Intensive Care,

Cairns Base Hospital,

Cairns 4870,

Australia

* *Corresponding author*