

## Comment on: A bench test of a modified gastro LMA for the insertion of the duodenoscope

Sir,

We read with great interest the article by Zilberman *et al.*<sup>[1]</sup> regarding modification of the LMA® Gastro™ airway(LGA). We commend them for their thoughtful improvisation, but the clinical scenario is very different, and its practical utility is doubtful.

The authors have cut the device close to the 'knee' well above the mask. This arrangement will defeat the very purpose of LGA and will only help guide the endoscope till the pharynx. The inflated mask can still compress the endoscope and hinder any advancement or rotational movements during ERCP. Rough edges created are likely to graze on the pharyngeal mucosa and cause injury.

The authors mention that gastro channel is 14 mm wide. However, it has a uniform 16 mm lumen without any 'knee' and is suitable for all endoscopes up to 14 mm<sup>[2]</sup> The diameter of most gastro-duodenoscopes is 13.1-13.7 mm and only 2 mm play is required for the passage of endoscopes in the lumen. In our clinical experience, a well-lubricated shaft helps navigate even bigger endoscopes and any resistance is generally felt only at its distal end.<sup>[3]</sup> Use of silicon spray provided us a better lubrication than use of a jelly. A large series in the past has reported 99% success for gastroduodenoscopies with high endoscopist satisfaction using LGA.<sup>[4]</sup>

We think that further design modifications like wider gastro-channel, reinforcement of the distal end of the LGA to reduce compression by inflated cuff, making the distal tip more oblong would go a long way in overcoming the present limitations and increasing its acceptance.

### Financial support and sponsorship

Nil.

### Conflicts of interest

There are no conflicts of interest.

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**Submitted:** 06-Mar-2022

**Accepted:** 07-Jul-2022

**Published:** 22-Jul-2022

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Access this article online	
Quick response code	Website: www.ijaweb.org
	DOI: 10.4103/ija.ija_232_22

**How to cite this article:** Gupta A, Gupta N. Comment on: A bench test of a modified gastro LMA for the insertion of the duodenoscope. *Indian J Anaesth* 2022;66:546.

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