



Awake supraglottic airway guided flexible bronchoscopic intubation

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Letter to the Editor

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I read with great interest the narrative review on awake supraglottic airway guided flexible bronchoscopic intubation in patients with anticipated difficult airways by Lim and Wong [1]. Undoubtedly, awake intubation is indicated in a patient when difficulty in maintaining or securing the airway after induction of general anesthesia is expected. The natural airway is better maintained in the awake patient. The normal muscle tone helps to maintain the anatomy and easier identification of upper airway structures relative to each other. There is less likelihood of aspiration with preservation of the lower esophageal sphincter tone and maintenance of spontaneous breathing; besides, the patient can follow instructions while awake. However, awake intubation requires careful patient preparation, adequate topical anesthesia of the airway, and judicious use of sedative agents; besides, an appropriate level of operator expertise. The insertion of a supraglottic airway device (SAD) seated in the pharynx above the laryngeal inlet attenuates the pressor and laryngeal responses [2]. It is reasonable to assume that in the awake patient, an SAD may be better tolerated than an endotracheal tube. The SAD serves as a conduit for fiberoptic bronchoscope-guided endotracheal intubation and, if positioned correctly, leads to easier and more rapid endotracheal intubation. The Difficult Airway Society guidelines for the management of the unanticipated difficult airway [3] and the American Society of Anesthesiologists Difficult Airway algorithm [4] suggest intubation through an SAD in case of failed tracheal intubation. Insertion of an SAD in the awake patient under topical anesthesia followed by tracheal intubation after induction of general anesthesia has been reported previously [3]. In their narrative review, Lim and Wong describe inserting an Ambu Auragain™ SAD after topical anesthesia of the airway and remifentanyl infusion. Fiberoptic bronchoscope-guided tracheal intubation was achieved through the SAD. However, it is not clear why the authors did not inflate the SAD cuff. The position of an SAD is usually confirmed after cuff inflation. Cuff inflation permits the formation of a seal between the device and the pharyngeal mucosa; besides, the use of a second-generation SAD also allows isolation of the respiratory and alimentary tracts. Cuff inflation also prevents device displacement. There seems to be no recommendation in literature to leave the SAD cuff uninflated. Furthermore, insufflation of oxygen at 10–15 L/min through an oxygen tubing attached to the proximal end of the ventilation port of the SAD may lead to gastric insufflation, regurgitation, and pulmonary aspiration. The authors report supraglottic airway guided flexible bronchoscopic intubation in several cases. However, when coughing or patient movement during intubation is undesirable, as in patients with intracranial lesions or an unstable cervical spine, it may be prudent to administer general anesthesia with or without the use of muscle relaxants after confirmation of SAD position by fiberoptic bronchoscopy. This may be followed by assisted ventilation before attempting tracheal intubation through the SAD.

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Conflicts of Interest

No potential conflict of interest relevant to this article was reported.

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