

LMA Proseal for the surgical procedures in prone positioning

Sir,

We thank the readers for taking keen interest in our study and raising a few safety issues, which need clarification.^[1] The rationale for using ProSeal laryngeal mask airway (PLMA: IntraVent Orthofix, Maidenhead, UK) in the prone position was not only the accidental extubation in prone position, but the fact that if a technique (PLMA insertion in prone position) has been described for an emergency situation, the same can be used in a controlled elective scenario. Ours is not the first report of the use of PLMA in the prone position. There are several reports of PLMA use in prone position in adults for elective as well as emergency procedures.^[2,3] This technique allows the patient to lie at ease in a position where he/she is most comfortable. Our aim was to see if PLMA insertion in the prone position can reduce the time to surgical readiness and the number of personnel required to position these patients prone.

We fully agree that adequate planning and vigilance are cornerstones for prevention of any mishap and ensuring a successful outcome. Some anesthesiologists may never encounter any case of inadvertent extubation of the endotracheal tube in the prone position, but there is no denying of the fact that it does occur. The Fourth National Audit Project of the Royal College of Anaesthetists mentions the increased use of the supraglottic airway devices as a primary airway management device for general anesthesia.^[4] Any new technique or piece of equipment gradually gains acceptance and with time its scope of applications broadens. Anesthesiologists experienced in the use of PLMA are comfortable using it in different clinical scenarios.

We followed all the standard patient safety precautions in the proper prone positioning. There was no abdominal compression and no hyper-abduction of the arms. Adequate padding to the pressure points was provided as mentioned in the manuscript. The image seen in the photographs is the position taken by the patient himself, and the arms were kept above the head with the elbows flexed and supported. The picture describing the insertion technique was taken from the head end and therefore, it did not show free abdomen, which can be seen only in a side view. If one looks carefully, side arm boards can be seen.

We defined the surgical readiness time from induction of anesthesia till the patient was finally positioned and handed over to the surgeon. Hence, the starting point as well as the end point were the same in both groups.

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