
Looped suction catheter in an i-gel™; something to worry about or much ado about nothing?

Sir,

We describe a case in which a suction catheter inserted through the gastric drain channel of an i-gel™ (size 3) was found emerging into the shaft (airway channel). The semitransparent nature of the device enabled its recognition. We discuss the clinical implications of the suction catheter malpositioning in the airway device and suggest preventive and remedial measures.

A 22-year-old female patient with American Society of Anesthesiologists physical status I (ASA PS I) scheduled for nanofat grafting for a scar over left forehead was administered general anaesthesia and the airway was

secured with i-gel™ (size 3). A 10 Fr suction catheter was inserted smoothly through gastric drain channel without resistance. Anaesthesia was maintained with spontaneous ventilation under a 40:60 oxygen-nitrous mixture with a total of 1 MAC sevoflurane. The surgical duration was 1 h and no issues with ventilation or oxygenation were noticed on the standard monitors. A careful examination through the semitransparent shaft of the airway device revealed a looped suction catheter which was also confirmed after removal of the i-gel™ at the end of surgery [Figure 1a and b].

Impaction of suction catheter in preformed nasal endotracheal tube (ETT) has been reported in a paediatric dental patient.^[1] Resistance to pull out suction catheter, which has entered Murphy eye of ETT has been described by Jagannathan and Pak.^[2] Gupta *et al.* reported a case of impaction of suction catheter within ETT even though the catheter was of recommended size and there was no knotting inside the ETT.^[3] Dubey and Sanjeev have



Figure 1: (a) Intraoperative photograph of the i-gel with the retrograde suction catheter tip (Red arrowhead) seen through the semi-transparent ventilating port. (b) The course of the suction catheter after removing the i-gel en masse

reported impaction of suction catheter in paediatric ETT as these ETT have a smaller lumen and sharper curve.^[4] Perilli *et al.* proclaimed improved success rate during ProSeal laryngeal mask airway (PLMA) insertion using suction catheter. They showed the main cause of failed PLMA insertion with suction catheter technique was misplacement of the suction catheter.^[5] Our patient did not have any gastric regurgitation but a looped suction catheter increases risk of aspiration of gastric contents because i-gel™ has lower sealing pressures among the second generation supraglottic airway devices, making it less safe for patients at increased risk of aspiration. This report brings to light that such unexpected complications may occur and thus a prompt visual inspection of the transparent body of the i-gel™ after insertion should be made to recognize any malpositioning of the suction catheter. Correct placement of the suction catheter in the gastric tube should be assessed by conventional auscultation method. Supraglottic airway devices are associated with various complications.^[6] This is the first report of a malpositioned suction catheter within the i-gel™.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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