

Safety of Supraglottic Airway-reinforced Laryngeal Mask Airway during Intranasal Surgery

The recovery stage of general anesthesia (GA) includes patient becoming awake from unconscious stage and regains complete consciousness. It differs neurobiologically from the induction phase of general anesthesia.¹ Pharmacological factors which influence this phase include general anesthesia drugs, skeletal muscular relaxants, sedatives, hypnotics, and pain-killing drugs. Opioids, other factors which may influence are electrolyte disorders or hypothermia during the surgery. Extubating occurs when all the airway reflexes have returned, with goal in nasal surgery is to prevent coughing, straining, and retching, to avoid venous congestion or bleeding. Main aims in perioperative anesthesia during intranasal surgeries are to provide clear surgical field, smooth recovery from GA and early discharge.

Traditionally cuffed tracheal tubes are used for the ENT surgery for protection of the airway from surgical blood/debris during anesthesia. Studies comparing reinforced laryngeal mask airway (RLMA) to endotracheal tube (ETT) in nasal surgery have shown efficacy in achieving the above functions.²⁻⁹ However, its usage and practice worldwide is a lot slower than expected. This has led to healthy debates in the scientific community.

The most popular airway device for intranasal surgery worldwide is endotracheal tube. However, recently laryngeal mask airway has gained popularity and has been proved in the literature that it is also a safe airway device for intranasal surgeries.¹⁰ RLMA has advantage of not requiring neuromuscular blockade or throat pack and provides positive pressure ventilation. The insertion comes with repeated practice. It is important to have leak-free confirmation tests (airway sealing pressure between 12–15 cm H₂O) for its placement to maintain adequate ventilation without hypercarbia. It is very important to understand this technique and practice it so that both the surgeon and the anesthesiologist will have a first-hand information of the procedure. If patients are selected well, we hardly see any patient getting aspirated or develop laryngospasm. It is said that RLMA may be better than ETT in preventing airway complications after nasal surgery.⁷ Individual hospital protocol may be drawn for preoperative selection of ENT patients highlighting perioperative vigilance with rescue devices and good understanding between the anesthetic, surgical and nursing departments in safe conduction of anesthesia.

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