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Awake supraglottic airway guided intubation. For the patient, by the patient.

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Awake supraglottic airway guided intubation: for the patient, by the patient

- Letter to the Editor -

To the editor,

We read with great interest an article by Lim and Wong [1] describing supraglottic airway guided flexible bronchoscopic intubation (SAGFBI). We congratulate them for highlighting this method which can be very useful in certain circumstances as described by them. In this regard we wish to add our experience of this technique as we also practice this method regularly. Informed written consent has been obtained for presentation and publication of cases from patients.

The most important suggestion we wish to make regarding this method is that at our institute we allow the patient to gently introduce the supraglottic device himself (Fig. 1). We believe it is better than allowing an anesthesiologist to put a device in the oropharynx of the awake patient even though gentle assistance is often required despite assurances. Often we see that the oral anesthesia is not adequate and gag reflex persists despite all methods. A person introducing the device himself does so making subtle adjustments to suit his comfort and at his own pace. This empowerment to participate in his treatment lessens his anxiety associated with the procedure and enhances his cooperation which is mandatory in an awake procedure. It results in lesser trauma and coughing or gag. We place the person at 45 degree head up position and the anesthesiologist stands behind to provide assistance and keep an eye on the placement itself. For trouble shooting in such cases, an alternate lateral approach by the side of mouth is required sometimes. Assisted by an anesthesiologist the patient can himself, again manipulate the device in a gentler and less traumatic fashion.
The choice of device also has a bearing on success of the technique. The authors have described advantages of Ambu aura gain versus Proseal. We feel that a preformed second generation device with an inflatable cuff would be a good choice. Devices like Intubating LMA or Proseal LMA which have metallic introducers [2]. This may not be suitable for the purpose of awake placement due to the hard non malleable metal. i-gel has been attempted in an awake patient for difficult airway management [3]. There has been a study in which authors have described successful use of i-gel as a conduit for intubation using a fiberscope in sedated patients. However, there have not been any comparison of devices and even in this study, patients were not fully awake [4]. We have noted that i-gel is not very comfortable for awake placement. It has wide and hard shaft with non-inflatable cuff [5]. The gag elicited from this device is stronger than many other supraglottic devices though no trials have been performed comparing any device for awake placement. To reduce the gag reflex associated with awake placement of such devices, we encourage patients to gargle with lignocaine keeping the solution for as long as they can, in the oral cavity. We then ask them to gently swallow it all. We believe this allows for better anesthesia of the oropharynx and also a part of upper esophageal sphincter region. We authors feel that by taking above mentioned measures we can ensure better patient management when practicing supraglottic airway guided flexible bronchoscopic intubation (SAGFBI).


References


Figure legend

Fig. 1. Note the patient holding a supra glottic device in his dominant hand and about to place it in his own oropharynx.