Letters to Editor

Reverse technique for I-gel supraglottic airway insertion

Sir,
The I-gel™ (Intersurgical Ltd, Wokingham, UK) is a single-use extraglottic airway device with a non-inflatable cuff and an esophageal vent. The device is used for maintaining the patency of airway during cardiopulmonary resuscitation for short surgical procedures and as a conduit for endotracheal tube insertion in difficult airway. I-gel has been compared with other extraglottic airway devices for ease of insertion. Most airway training manikin studies report a high success rate of >95%, even by inexperienced personnel. When I-gel was used for airway management in adult patients, a first time success rate of 86% has been reported. Authors required 53 manipulations in 26 patients to achieve a clear airway. A problem of tongue folding during I-gel placement has been reported, though the patient had adequate mouth opening and full set of dentition.

We successfully used the reverse insertion technique for I-gel airway in a 30-year-old woman, scheduled for hysteroscopic dilatation and curettage. The technique has been previously described for the insertion of Guedel’s airway and classic Laryngeal Mask Airway (LMA). Our patient received an induction dose of propofol, and I-gel was initially inserted orally using the standard insertion technique. However, the device could not be positioned properly due to repeated tongue folding. A reverse insertion technique, as reported for classic LMA, was then tried. The I-gel was inserted with concavity facing toward the hard palate. On reaching oropharynx, the device was rotated 180° and placed in its final position to facilitate positive pressure ventilation. This method is easy to use, atraumatic, and may be used for I-gel insertion if first attempt by classic technique fails.

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Sir,

Anesthetizing the glossopharyngeal nerve (GPN) is an important component in achieving successful airway anesthesia and is necessary for both awake oral and nasal tracheal intubations. The clinician should recall that the GPN is the IX cranial nerve and that it innervates the posterior third of the tongue, epiglottis, as well as the soft palate.

Anatomically, the intraoral GPN nerve block can be accomplished by injection of local anesthesia at the base of either the anterior or posterior tonsillar pillars. This can be facilitated by using a laryngoscope, held sideways, for medial retraction of the tongue [Figure 1]. It is the authors’ observation that this provides excellent visualization of these structures; with less potential for gagging than traditional caudal tongue retraction. When held in this manner, the laryngoscope subsequently also functions as a bite block.

Typically, a 22 to 25 gauge Quincke point spinal needle is then used to inject 4 to 5 ml of 2% lidocaine. For patients with small mouths, limited inter-incisor distance, or with mild to moderate trismus, pediatric laryngoscopes may be used. Furthermore, Miller laryngoscope blades, which are usually narrower than Macintosh, may also be advantageous.

In addition, the use of a video laryngoscope such as the Glidescope® may also facilitate proper localization. This device may also be educationally valuable.

For those patients with severe trismus, the extraoral GPN block may be necessary. Careful aspiration is always essential with either the intraoral or extraoral approaches; as the GPN is located near the carotid artery. In addition, "redundant" local analgesic techniques, with topicalization of the tongue as well as nebulized lidocaine, are beneficial prior to performing this block. Use of both the transtracheal and superior laryngeal nerve blocks are also indispensable for awake tracheal intubation. Whereas topical anesthesia, of the sphenopalatine ganglion and nasal mucosa, are additionally needed for awake nasal intubation. Judicious use of intravenous sedatives may also be beneficial.

Pretreatment with sodium citrate and metoclopramide is necessary if a "full stomach" or gastroesophageal reflux is known or suspected.

The patient's ability to tolerate either a traditional Berman or Guedel oral airway may be used as an indication of adequate overall intraoral anesthesia. Fiberoptic-compatible oral airways should also be available.

It should be noted that awake intubation can be accomplished with a traditional laryngoscope, video laryngoscope, or fiberoptic bronchoscope. "Blind" intubation techniques can also be employed. These may be facilitated with the use of an

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