Supraglottic airways and their use in fibreoptic intubation

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Introduction:
Supraglottic airways have a very important role as an acceptable 'plan B' in management of failed laryngoscopy. They provide patent airway facilitating ventilation and oxygenation during attempts for tracheal intubation. They can also serve as a conduit for tracheal intubation shortening the distance to the vocal cords.
They have been used for asleep fibreoptic intubation in both unexpected and expected (children, patients with genetic syndromes and learning disabilities) cases. They have been used even for awake intubation in the morbidly obese patients and in these with cranio-facial abnormities. Trachea may be intubated through them blindly using a gum elastic bougie, 'Aintree' intubating catheter or specially designated soft tracheal tube (ILMA). Fibrescope-guided techniques have generally higher success rate and can avoid a trauma caused by blind insertion of intubating catheter or tube.
Various devices have been in use:

A) Intubating laryngeal mask airway – allows both 'blind' and fibreoptic tracheal intubation
B) Standard laryngeal mask airway – allows fibreoptic intubation or 'blind' intubation with bougie. An exchange technique must be used.
C) I-gel supraglottic airway – allows both 'blind' and fibreoptic tracheal intubation and insertion of tracheal tube directly through a wide bore.
D) Other devices – Supreme LMA, Cobra, SLIPA, COPA – not routinely used in clinical practice.

The authors present their experience with fibreoptic intubation through various supraglottic devices.

Literature:
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