

Correspondence

Flexible laryngeal mask airway for head and neck oncological surgery?

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EDITOR:

We read with interest Drs Martin-Castro and Montero's report on the use of the flexible laryngeal mask (FLMA) as an alternative to reinforced tracheal tube for upper chest, head and neck oncological surgery [1]. We seek some clarifications from them with regard to the operations concerned. How many of the patients whose airways were managed with the FLMA had oro-pharyngeal malignancies? What reconstructions were performed? Were there any postoperative tracheal intubations?

The term 'head and neck oncological surgery' conventionally refers to resection of head, face and neck (or oral, pharyngeal and laryngeal) tumours followed by reconstruction using local, regional or microvascular free tissue flaps [2]. These tumours often result in anticipated difficult airways and additionally may require nasotracheal and/or fiberoptic intubation or preoperative tracheotomy [3–5]. Airway management decisions are also based on the complexity of the planned reconstruction or the need for postoperative ventilation [6]. In our opinion, the airway management in head and neck oncological surgery differs from upper chest (specifically breast oncological) surgery. In the former, the laryngeal mask airway device can be used to temporarily secure the airway, as a conduit for fiberoptic intubation or offer a rescue technique before or after surgery. Therefore, while the FLMA, as these authors have reported, would be useful for breast oncological surgery, it may have a limited role in the

perioperative airway management for head and neck oncological surgery.

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