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LETTER TO THE EDITOR

The use of laryngeal mask airway in tonsillectomies

I read the article written by Ranieri Junior et al.[1] in your journal and aggree with the authors' take. The use of a laryngeal mask airway in adenotonsillectomies is possible; however, the tracheal tube is safer compared to the laryngeal mask. In recent publications, the use of LMA is reported superior to endotracheal entubation at adenotonsillectomy operations.[2,3] I believe that LMA use for pediatric tonsillectomy and adenoidectomy is associated with a higher incidence of complications. I consider the LMA tonsillectomy technique important to use. Previously published studies have rarely reported the importance of the tonsillectomy technique. Cold tonsillectomy bleeding rates are greater than in the hot tonsillectomy techniques (bipolar, thermal welding, coblation, laser).[4] In the cold technique, the use of LMA can lead to blood aspiration; bleeding control is quite difficult if the sutures are used in the tonsillar fossa. Furthermore, placement of LMA in the mouth of younger children, and grade 4 hypertrophy of tonsils do not provide enough surgical visualization. Thus, I would not suggest the use of LMA in tonsillectomy, except in specific cases.

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LETTER TO THE EDITOR

Reply to Alper Nabi Erkan

I appreciate Prof. Erkan's comments regarding my recent article - *The use of disposable laryngeal mask airway (LMA) for adenotonsillectomies*[1] - with particular emphasis on patient safety.

Recent publications show the LMA's superiority over tracheal tube considering respiratory complications in adenotonsillectomies.[2,3] In my study, I did not use the enforced spiral LMA and there were no statistically differences in respiratory complications between the groups. Nonetheless, it was necessary to exchange three patients' LMA for an endotracheal tube due to gas leaking with cervical hyperextension for surgery. Another patient had values of oxygen saturation down to 58% after gastric regurgitation and a tracheal tube had to be inserted.

Thus, in patients with hypertrophied tonsils, sometimes the laryngoscope has to be used to correct LMA positioning or even to replace it by a tracheal tube.

Considering the surgical approach and technique, the use of sutures and especially hot techniques may be related to other postoperative complications and pain.[4] A uniform surgical technique, including the use of bismuth subgallate and reassessment of the tonsillar fossae before taking out the respiratory device, reduces the incidence of primary tonsillar hemorrhage. Despite this fact, according to my experience and research, I agree with Dr. Erkan and do not encourage the use of LMA for tonsillectomies.

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