Laryngoscopy and intubation are procedures that have the distinct feature of duality: on the one hand they can be considered routine and be life-saving measures, but on the other hand the complete opposite: not only can they be extremely difficult, sometimes impossible, and if not properly performed they can lead to severe morbidity and to irreversible life threatening conditions and ultimately brain anoxia and dead. Contrary to popular belief the skills of laryngoscopy are not only inherently difficult to acquire but also deteriorate over time if not practiced routinely. [1-4] The most common method of intubation in the emergent setting is via the oral route and still to date the most common method of intubation is via direct laryngoscopy (DL) with either the Miller blade released in 1941 or the Macintosh blade released in 1943. From their inception is been apparent that although statistically either blade or both have a relative good track record, they are not even close of being 100% effective and numerous modifications of them have appeared claiming superiority to the original blade in certain populations or in the presence of certain patient and facial features (to be fair no airway device has or ever will be 100% effective, unless you consider oxygen as a device). Historically many strategies and plans have been devised to overcome their deficiencies: among them the use of stylets, the use of optimal external laryngeal manipulation, the use of the gum elastic bougie (eshman bougie) and the use of the ASA DA Algorithm; a plan to evaluate, plan, execute and recognize potential problems with airway management and use alternatives in case the original plan or plans have failed, this in an attempt to increase the chance of successful airway management and to decrease the chances of adverse events related to it. [5-13] Other alternatives to intubation via DL have been Combitube introduced in the 1980’s, Cricothyroidotomy kits introduced in 1985, Bullard laryngoscope in 1989, laryngeal tubes in 2000; but one of the most important advances in airway management of the second half of the 20th century was the introduction of the LMA, a device introduced into the U.S in 1992 (in the U.K in 1988) and developed by Archibald Brain as an alternative to either E.T.T or face mask ventilation. The LMA is considered to be the most important development in airway management of the second half of the 20th century, and is the only noninvasive device explicitly recommended by the ASA Algorithm for the management of the difficult airway. To date this device (s) have been used extensively all over the world and have received considerable attention in the medical literature. [14-28] A complete review of the LMA is beyond the scope
of this brief review, but an attached .pdf shows in a graphic the history and evolution of the LMA is included. As early as 1983 when Dr. Brain was working on the development of his novel airway device he saw the potential of his invention not just as an alternative to intubation and as a definite airway but also as a conduit for intubation and he started working on a prototype to make the LMA as a tool for this purpose; he finally released the Fastrach LMA or Intubating LMA (ILMA) in 1997. [29-33] The Fastrach LMA is an advanced LMA with dual function of allowing oxygentation and ventilation and also to allow either blind or Fiberoptic guided endotracheal intubation; it has been shown in some studies to be superior to the Macintosh blade and comparable to newer Videolaryngoscopy systems [34] It is user-friendly, relatively easy to use and has a high success rate for intubation even for novice users and requires less skill than conventional intubation by DL; its use has been reported with increase frequency not just in the hospital setting but outside the hospital as well including in trauma victims [35] More recently a disposable version of Fastrach LMA was released in 2005 and a newer Video Fastrach LMA called the C-Trach LMA a more costly alternative that was released in 2006 . This C-Trach LMA has been shown in some studies to be superior to conventional Fastrach for blind and FO assisted ETT placement; however its use may be limited in some patients due to presence of blood and/or secretions in the pharynx.[29,36,37] Another method that has been described to help with intubation via the Fastrach LMA has been the use of Fiber-optic assistance through a hollow bougie called the Aintree device. The use of this technique has been shown to be extremely useful in some patients and has been used as a rescue airway technique with great success in the literature.[38-42] REFERENCES/RECOMMENDED READING


http://felipeairway.sites.medinfo.ufl.edu/
38. Avitsian, R., et al., Successful reintubation after cervical spine


