decompressed by aspiration of its contents using a 16G needle. Approximately 150 mL of thick brown oily fluid was aspirated, resulting in dramatic collapse of the cyst (Figure 2). At this stage, the airway assessment revealed normal mouth opening with a Mallampati class 1 airway. Accordingly, it was deemed appropriate to proceed with general anesthesia following application of routine monitors. Following induction with thiopentone sodium 75 mg *iv* (5 mg·kg^{-1}) and atracurium 7.5 mg *iv* (0.5 mg·kg^{-1}), direct laryngoscopy revealed a laryngeal grade 1 view (Cormack and Lehane classification), and the patient's trachea was intubated with a # 5 oral endotracheal tube. The patient's lungs were ventilated and anesthesia and surgery proceeded without incident. Following complete excision of the lesion, the patient's recovery was uneventful.

Although collapsing a cyst by needle aspiration is a commonsense approach, surprisingly this technique has not been adequately highlighted in the literature.[1] Only on five previous occasions has *partial* cyst decompression been reported to facilitate intubation.[1] This is the first reported pediatric case of *complete* preanesthetic decompression of a giant sublingual dermoid cyst.

Huge intra-oral cysts also hinder surgical access. Therefore, extra-oral submental access, median glossotomy, extended median glossotomy and mandibulotomy approaches have been described.[2–4] They increase morbidity and are cosmetically unacceptable. The case reported herein illustrates that preanesthetic aspiration improves surgical access, thereby facilitating complete transoral excision of giant cysts.

We wish to caution that needle aspiration of cyst is only a temporizing measure and it cannot be the definitive treatment. Although aspiration may occasionally fail due to the pultaceous nature of cyst content,[1] we emphasize that it is worth attempting in every case. We extrapolate that this technique may be applicable in any huge cystic lesion of the oral cavity[5] irrespective of its pathology.

Venkatachalam Raveenthiran M Ch
Cenita J. Sam M Ch
Souna K. Srinivasan MD
Annamalai University, Tamilnadu, India
E-mail: vrthiran@yahoo.co.in
Accepted for publication August 15, 2006.

References

1 *King RC, Smith BR, Burk JL.* Dermoid cyst in the floor of the mouth. Review of the literature and case reports. Oral Surg Oral Med Oral Pathol 1994; 78: 567–76.

2 *Pashley NR.* Massive dermoid cysts of the floor of the mouth in children. Int J Pediatr Otorhinolaryngol 1981; 3: 355–63.

3 *Di Francesco A, Chiapasco M, Biglioli F, Ancona D.* Intraoral approach to large dermoid cysts of the floor of the mouth: a technical note. Int J Oral Maxillofac Surg 1995; 24: 233–5.

4 *Longo F, Maremonti P, Mangone GM, De Maria G, Califano L.* Midline (dermoid) cysts of the floor of the mouth: report of 16 cases and review of surgical techniques. Plast Reconstr Surg 2003; 112: 1560–5.

5 *Kumar KV, Joshi M, Vishwanath N, Akhtar T, Oak SN.* Neonatal lingual gastric duplication cyst: a rare case report. J Indian Assoc Pediatr Surg 2006; 11: 97–8.

Modification of the LMA-Unique to facilitate endotracheal intubation

To the Editor:

Airway management can present challenges during conscious sedation for specialized cases performed under regional or local anesthesia such as awake craniotomy.[1,2] When progressive sedation levels are required, initially the airway can be managed with the laryngeal mask airway (LMA; LMA North America, San Diego, CA, USA) or the single-use LMA-Unique (LMA-U).[3] If airway protection is needed or positive pressure ventilation is required, conversion to an endotracheal tube (ETT) may then be warranted. Blind passage of a standard ETT through the LMAU is rarely successful, with less than 25% success in one series[4] but fibreoptic guidance may provide visualization for intubation.[5] We have modified an LMA-U and ETT to successfully secure the airway.

A middle-aged patient underwent awake craniotomy in right lateral decubitus position with his head fixed in Mayfield pins. After cerebral mapping was completed the patient was re-sedated, but he then became increasingly restless; it was impossible to find a balance of immobility and comfort without airway obstruction and apneic events. A size 4 LMA-U was inserted, allowing the patient to breath spontaneously. After three hours, gastric contents appeared in the anesthesia circuit, mandating endotracheal intubation to protect the airway. The fibreoptic bronchoscope (FOB) was advanced easily into the trachea with the LMA-U in place. However, a bed-side trial of similar components revealed that a suitably sized ETT could not be advanced through the LMA-U. A larger #5 LMA was not helpful because the limiting factor was the circuit connector. The intubating LMA could not be inserted properly due to the patient's position. A

TABLE Equipment combinations for intubation through LMA-Unique

LMA-Unique size	*New connector (standard ETT)*	*Armoured tube (Mallinckrodt)*	*"Pusher" tube (standard ETT)*
3	8.5	6.0	6.0
4	8.5	6.5	6.5
5	9.0 + 2 turns of plastic tape	7.0	6.5

ETT = endotracheal tube.

solution was found to achieve fibreoptic assisted endotracheal intubation via the LMA-U. This was based on the following components: a modified LMA-U, armoured ETT, and a cut ETT to be used as a "pusher", if removal of the LMA-U was necessary.

The circuit connector plus 2–4 cm of the tube can be cut from the LMA-U and replaced with a lubricated connector from a standard size 8.5 ETT. The LMA-U with removable connector can be inserted in the usual fashion and used to ventilate the patient. If endotracheal intubation is required, the LMA-U circuit connector is removed and an armoured ETT can be advanced over a FOB into the trachea under direct guidance. The ETT can then be used to ventilate the patient with the LMA-U *in situ* (cuff deflated). The armoured ETT is preferable because it has a more proximal exit point for the pilot balloon, facilitating LMA-U removal, and because it has a smaller balloon, which deflates without kinking to allow easier passage through the LMA-U. The Table shows the applicable sizing for the required components.

If the LMA-U is to be removed leaving the ETT *in situ*, the armoured ETT circuit connector should be removed in advance by working a snap underneath the seal to loosen it. The ETT connector can then be intermittently detached as well. A "pusher" to hold the ETT in place while removing the LMA can be made by excising the cuff and the proximal portion of a #6.5 ETT at the pilot balloon exit point.

In situations where the intubating LMA cannot be used because of patient or positioning factors, application of the LMA-U with this modification may become especially useful to facilitate endotracheal intubation with fibreoptic guidance. This technique could also be potentially useful in a situation where intubation is desired and the LMA-U is already *in situ*. The ETT connector could be cut from the LMA-U and replaced with the detachable connector, although it goes against conventional wisdom to sever the connector from an *in-situ* airway device. A limitation of this technique is that currently available sizes (3, 4, and 5) of the LMA-U limit maximal ETT sizes to 6.0, 6.5, and 7.0, respectively.

With this modification, the disposable LMA-Unique can be used to assist with tracheal intubation when transitioning from conscious sedation to general anesthesia, or in a situation where intubation through an LMA is the preferred option to secure the airway. With increased use of the disposable LMA-U, this technique may become a valuable tool in the anesthesiologist's airway armamentarium.

Timothy P. Turkstra M ENG MD
Hélène G. Pellerin MD
University of Western Ontario, London, Canada
E-mail: tturkstr@uwo.ca
Accepted for publication September 7, 2006.

References

1 *Sarang A, Dinsmore J.* Anaesthesia for awake craniotomy - evolution of a technique that facilitates awake neurological testing. Br J Anaesth 2003; 90: 161–5.
2 *Costello TG, Cormack JR.* Anaesthesia for awake craniotomy: a modern approach. J Clin Neurosci 2004; 11: 16–9.
3 *Cook TM.* The classic laryngeal mask airway: a tried and tested airway. What now? (Editorial). Br J Anaesth 2006; 96: 149–52.
4 *Barnes DR, Reed DB, Weinstein G, Brown LH.* Blind tracheal intubation by paramedics through the LMA-Unique. Prehosp Emerg Care 2003; 7: 470–3.
5 *Osborn IP, Soper R.* It's a disposable LMA. Just cut it shorter – for fiberoptic intubation. Anesth Analg 2003; 97: 299–300.

Does propofol suppress nitrosative stress during aortic surgery in pigs?

To the Editor:
We applaud Rodriguez-Lopez *et al.*[1] for conducting a study in a clinically relevant large animal model detailing that propofol, when applied in a clinically relevant dose, reduces the systemic inflammatory response, renal superoxide anion production, and subsequent lipid peroxidation during aortic surgery compared to the volatile anesthetic sevoflurane. In their study, the inflammatory cytokine tumour necrosis factor-α (TNF-α) increased significantly and progressively at 15 min after aortic declamping, reaching peak concentrations after 72 hr in the sevoflurane group. In contrast, post-ischemic serum concentrations of TNF-α were significantly lower in the propofol group. Propofol attenuation of serum levels of TNF-