Also known as a laryngeal mask



Objective

To safely secure and maintain control of the airway in a newborn with an anticipated or unexpected difficult airway, or when the operator does not have skills in newborn intubation.

Indications

- Face mask ventilation is unsuccessful: Congenital anomalies, large mask leak/no chest rise
- Endotracheal intubation is unsuccessful: Consider SGA after 2 intubation attempts
- The need to secure airway by personnel without skills in neonatal intubation (medical/ nursing/midwifery, if credentialed to use a supraglottic airway)
- Infants ≥34 w, >1500g (weight based on recent published evidence, i-gel® states ≥ 2 Kg)
 - SGA has not been tested for safety and efficacy of endotracheal adrenaline administration



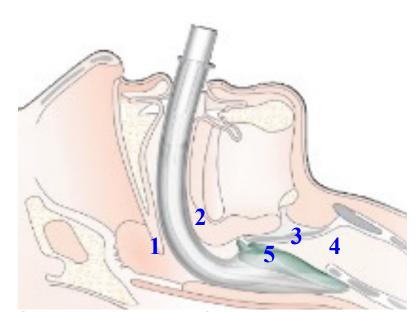
Equipment

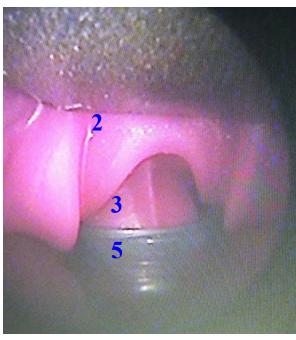
- Supraglottic airway size 1
- Lubricant: baby's own saliva (if insufficient use branded lubricant)
- Suction apparatus and suction catheters (8 & 10 Fg)
- Stethoscope (preferably neonatal size)
- Colorimetric CO₂ detector (Pedi-Cap®)
- Tape to secure SGA
- T-piece/SIB with appropriately sized face-mask
- Nasogastric tube size 8 Fg
- (5 mL syringe for a cuffed SGA)

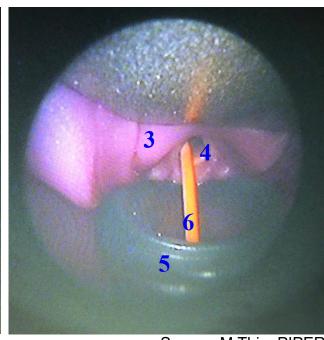




Anatomical references







Source: Intersurgical i-gel flyer

Source: M Thio, PIPER

SGA anatomical points: 1 soft palate, 2 posterior part of the tongue, 3 epiglottis, 4 vocal cords, 5 SGA rim (6 bougie inserted through SGA into the vocal cords for anatomical reference)



Procedure

- Hold the supraglottic airway like a pen
- Slide the back of it against the hard palate and into the pharynx until resistance is felt
- The tongue may need to be depressed to facilitate passage of the supraglottic airway
- If cuffed SGA: check cuff first, inflate it at the end (~4 mL of air)

Complications

- Inadequate alveolar ventilation (set PIP/PEEP may not be achieved due to leak)
- Gastric distension
- ? Vasovagal reaction

