

## Left handed laryngoscope : a new look at an old instrument

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Giant facial tumors like parotid masses present with both functional and aesthetic consequences due to the proximity of the facial nerve and the glands' alignment with the contours of the mandible (1). This altered contour of the mandible may cause airway problem during induction of anesthesia which is of special concern to the anesthesiologist.

A 65-year-old lady presented with a giant mass in the parotid region for excision. Contrast enhanced computed tomography of the neck determined it to be a large exophytic mass, size of  $16 \times 12 \times 7$  cm in the region of ramus and angle of right mandible with parapharyngeal extension. The mass extended up to the angle of mouth (Fig. 1). Difficult mask ventilation was anticipated. Preoxygenation was possible with slight lateral traction on the mass. Anesthesia was induced with propofol, mask ventilation, being difficult as jaw thrust was not possible on the right side. Ventilation was facilitated after insertion of an oral airway. Subsequently, suxamethonium was administered and intubation attempted with a right handed MacIntosh laryngoscope. Intubation was difficult since the mass prevented proper positioning of the laryngoscope in the right angle of the mouth. We turned the head rightwards while lateral traction was applied on the mass, and we introduced the laryngoscope from the left angle of the mouth. These maneuvers along with gravity aided in successful intubation. Although intubation was performed uneventfully, the use of a left handed laryngoscope (LHL) or a fiberoptic bronchoscope would have been preferable, but none of them were available. The tumor weighed 2900 g. The patient gave her consent for publication including an illustrative picture.

Pope has described a difficult intubation due to a unilateral bony swelling of the upper jaw. This was the first report we found which has highlighted the importance of the availability of a left handed laryngoscope (2). It is surprising that even after almost 50 years the use of left handed laryngoscope (LHL) is still unpopular. When the airway pathology involves part of the right side or exclusively the whole of the right side there is no room to position



Fig. 1. — Giant parotid tumor extending upto the angle of mouth making the use of right handed laryngoscope difficult.

a normal right or straight blade. In such cases, LHL can be used leaving an unobstructed left sided view of the glottis. Apart from the presence of a right sided lesion, other conditions in which it might be more convenient include dental lesions in the right side of the upper jaw, such as loose teeth, gapped teeth, or crown work, and injuries of the jaw or face where the right side is bound down by scarring. The use of left-hand laryngoscope blade is emphasized by ADHIKARY *et al.* (3). Although fiberoptic bronchoscope has become a modern and commonly recommended instrument for difficult intubation, its availability may be limited in many parts of the world. In fact many other anesthesiologists in the world may have faced a similar situation of missing a left handed blade.

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