

Gastro Congress 2017 : An evaluation of Gastro Laryngeal Tube (GLT) in patients undergoing ERCP under general anaesthesia and its comparison with endotracheal intubation - Global Journal of Digestive Diseases 2018 - Deepak Kumar Sreevastava - All India Institute of Medical Sciences (AIIMS), India

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Gastro Laryngeal tube (GLT) is a newly introduced supraglottic device specifically designed for Endoscopic retrograde Cholangio- Pancreatography (ERCP). It has a dedicated channel for the insertion of a Gastroscope and it also provides a separate patent airway whilst avoiding disadvantages of tracheal intubation. In a randomized controlled trial on 100 patients undergoing ERCP under GA, GLT was compared with endotracheal tube as an alternative airway device. Device insertion conditions, oxygenation and ventilation parameters were recorded. GLT was found to be comparable with ETT. Success rate of insertion of GLT was high (92%) and the insertion time of GLT was much shorter. Both the devices were equally effective in normal oxygenation and ventilation. The recovery time was significantly shorter and postoperative complications such as hoarseness and dysphonia were less common in GLT gp. Inserting conditions for the duodenoscope were better in GLT gp. In this study, likely to be first of its kind, it is concluded that the GLT is a suitable and better alternative to ETT as it allows adequate ventilation and is associated with faster recovery times and minimal extubation-related complications while enhancing operative conditions for gastroenterologists. Its regular use in patients undergoing ERCP is strongly recommended.

Endoscopic retrograde cholangiopancreatography (ERCP) is a complex and tedious method, which is commonly completed under moderate sedation which may bring about cardiorespiratory confusions, especially tranquilize prompted respiratory dependency and aviation route check. Moreover, ERCP is regularly done as an office technique in independent focuses requiring fastidious nonoperating room sedation (NORA) conventions.

A few patients related and strategy related variables require the utilization of general sedation with endotracheal intubation or supraglottic aviation route for ERCP. Some of them incorporate general feebleness and mature age, poor sustenance and hydration, poor American Society of Anesthesiologists (ASA) physical status, obstructive jaundice, unhinged liver capacities, discouraged aviation route reflexes with danger of goal, expanded odds of hypoxia, and yearning with profound sedation with an unprotected aviation route, and discouraged tone of muscles of the pharynx. Moderate sedation is related with agony and high-disappointment rates, while patients experiencing ERCP with profound sedation require same degree of care as those under general sedation (GA). Thus, it is reasonable to pick either endotracheal intubation or supraglottic aviation route to forestall hypoxia-incited cardiorespiratory difficulties.

Laryngoscopy and endotracheal intubation bring about bothersome hemodynamic reaction, which is most likely of little result in ordinary solid people however might be increasingly serious or inconvenient in patients with hidden comorbidities. It might prompt inconveniences, for example, myocardial localized necrosis, left ventricular disappointment, cerebrovascular mishaps, intracranial hypertension, and ascend in intraocular pressure. Endotracheal intubation requires the utilization of neuromuscular blocking drugs which is related with a more extended extubation time contrasted and the supraglottic aviation route and in this way draws out the recuperation.

An investigation led by Gaitini et al. has set up the way that gastro-laryngeal cylinder (GLT) is a viable aviation route for playing out the upper gastrointestinal (GI) endoscopy methods utilizing its endoscopic channel. The pressure reaction between supraglottic

aviation route, for example, GLT and endotracheal intubation have not been examined and requires further exploration. This investigation plans to contrast the pressure reaction with addition of GLT to that of endotracheal intubation in patients experiencing complex upper GI endoscopic strategies like ERCP. Complex gastrointestinal (GI) endoscopic methods like endoscopic retrograde cholangiopancreatography (ERCP) require profound sedation or general sedation. Comorbidities with the poor physiological condition warrant endotracheal intubation to forestall hypoxia and yearning. The gastro-laryngeal tube (GLT), another supraglottic aviation route gadget with a different channel for endoscope looks encouraging. Points: The point of the examination is to look at the pressure reaction during addition of GLT and endotracheal intubation (ETT) in patients experiencing upper GI endoscopic strategies like ERCP. Subjects and Methods: This control versus examination study involved two gatherings with 30 patients every who experienced ETT and GLT addition.

The standard general sedation procedure was utilized. In GLT gathering, the gadget was embedded without neuromuscular blocker. In ETT gathering, infusion atracurium 0.5 mg/kg intravenous was controlled as muscle relaxant for supporting endotracheal intubation. Hemodynamic boundaries and time taken for the addition of GLT/ETT were recorded. Factual Analysis: Data were broke down utilizing SPSS variant 20. Understudy's t-test was utilized to think about quantitative information between the gatherings. ANOVA test was applied for intragroup correlations among GLT and ETT gatherings. Clear cut factors were investigated utilizing the Chi-square test. Results: Heart rate and mean blood vessel pressure expanded from gauge in ETT gathering, following laryngoscopy and endotracheal intubation just as with GLT inclusion. Nonetheless, the pressure reaction brought about by endotracheal intubation was altogether more prominent than that brought about by GLT inclusion. End: GLT as an aviation route gadget is a sheltered option with diminished pressure reaction contrasted with endotracheal intubation for upper GI endoscopy methods.

Endotracheal intubation (EI) is regularly a crisis strategy that is performed on individuals who are oblivious or who can't inhale all alone. EI keeps up an open aviation route and forestalls suffocation. In a run of the mill EI, you're given sedation. At that point, an adaptable plastic cylinder is set into your trachea through your mouth to enable you to relax.

The trachea, otherwise called the windpipe, is a cylinder that conveys oxygen to your lungs. The size of the breathing cylinder is coordinated to your age and throat size. The cylinder is kept set up by a little sleeve of air that blows up around the cylinder after it is inserted. Your trachea starts just beneath your larynx, or voice box, and reaches out down behind the breastbone, or sternum. Your trachea at that point isolates and becomes two littler cylinders: the privilege and left fundamental bronchi. Each cylinder associates with one of your lungs. The bronchi at that point keep on isolating into littler and littler air sections inside the lung.

Your trachea is comprised of intense ligament, muscle, and connective tissue. Its covering is made out of smooth tissue. Each time you take in, your windpipe gets marginally more and more extensive. It comes back to its casual size as you inhale out. You can experience issues breathing or will most likely be unable to inhale at all if any way along the aviation route is blocked or harmed. This is when EI can be vital.