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A comparative study of supraglottic airway devices blockbuster LMA versus BASKA mask in adult patients undergoing laparoscopic cholecystectomy under general anesthesia

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ABSTRACT

Background: Supraglottic airway devices (SADs) have been extensively utilized as an alternative to tracheal intubation in the context of general anesthesia. **Aims and Objectives:** The study aimed to compare the utility of the new supraglottic airway Blockbuster and Baska Mask (BM) in patients undergoing laparoscopic cholecystectomy under general anesthesia. **Materials and Methods:** This prospective, single-blind, randomized study included 160 participants who underwent laparoscopic cholecystectomy at our tertiary care institute from May 2023 to May 2024. Participants were randomly assigned to two groups: Group I received the BM, whereas Group II received the Blockbuster laryngeal mask airway (LMA). The groups were compared in terms of demographic characteristics, ease of insertion, number of attempts, insertion time, oropharyngeal sealing pressure (OSP), adequacy of ventilation, hemodynamic changes, and complications. Independent samples t-test was used to compare continuous variables, whereas the chi-square test was used to assess associations between categorical variables. **Results:** The demographic characteristics of the two groups were comparable, with no significant differences ($P > 0.05$). Our findings indicated that the number of attempts, ease of insertion, insertion time, and hemodynamic variables did not differ significantly between the two groups ($P > 0.05$). **Conclusion:** Both SADs, the Blockbuster LMA and the BM, can be safely employed during general anesthesia and positive pressure ventilation for laparoscopic cholecystectomy. The Blockbuster LMA demonstrated a shorter insertion time compared to the BM, along with superior OSP.

Key words: Blockbuster laryngeal mask airway; Baska mask; Laparoscopic; Cholecystectomy; General anesthesia; Minimal invasive; ERAS

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INTRODUCTION

Laparoscopic cholecystectomy, a minimally invasive technique, has become the standard approach for gallbladder removal.[1] During laparoscopic procedures, CO_2 insufflation can strain the respiratory system, leading to potential complications such as air leakage, inadequate ventilation, and gastric insufflation, which increase the risk of aspiration.[2] As a result, general anesthesia with controlled ventilation has become the universal approach for laparoscopic surgeries.[3]

Challenges associated with endotracheal intubation (ETI) and airway-related complications have led to the development of supraglottic airway devices (SADs) as alternatives.[4] SADs have proven effective in routine anesthesia, offering advantages such as hemodynamic stability and reduced airway morbidity.[5] These devices

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provide a non-invasive way to maintain proper ventilation and oxygenation without requiring tracheal intubation and are effective for both spontaneous and positive-pressure ventilation.[6]

Introduced by Dr. Archie Brain in 1988, the laryngeal mask airway (LMA) revolutionized airway management with later designs incorporated gastric drainage and intubation channels.[7] More recently, the Blockbuster LMA, developed by Prof. Ming Tian, has emerged as an advanced option, offering a 95° angulated airway, ease of intubation, and a gastric port for suction. It is versatile, supporting both blind and fiberoptic-guided intubation.[8,9]

The Baska mask (BM), a second-generation SAD, features a cuff that conforms to the airway's shape, reducing risks of overinflation and gastric content aspiration. Its automatic cuff inflation during positive-pressure ventilation enhances oropharyngeal leak pressure (OLP), making it particularly effective for laparoscopic surgeries.[10,11]

Aims and objectives

The aim of this study is to compare the utility of the BM and Blockbuster LMA in American society of anesthesiologists (ASA) I and II patients undergoing laparoscopic cholecystectomy under general anesthesia.

The primary objective is to assess the number of insertion attempts, insertion time, ease of insertion and adequacy of ventilation between the two SADs and the secondary objective is to evaluate changes in hemodynamics, sealing pressures, and any potential complications.

MATERIALS AND METHODS

Study design

This prospective, single-blinded, randomized comparative study was conducted at Maharani Laxmi Bai Medical College, Jhansi, from May 2023 to May 2024. The study included 130 patients scheduled for elective laparoscopic cholecystectomy under general anesthesia, 65 in each group.

Inclusion criteria

- Age between 18 and 60 years
- Patients scheduled for elective laparoscopic cholecystectomy under general anaesthesia
- ASA physical status I or II
- Willing and able to provide written informed consent and follow study protocols.

Exclusion criteria

- Age <17 years or >60 years
- ASA physical status III or IV
- Difficult airway (Mallampati grade III or IV)
- Decreased lung compliance or high aspiration risk
- Emergency surgical cases
- Bleeding or coagulation disorders
- Head, neck, or oral surgeries

- Obesity (body mass index >28 kg/m^2)
- Refusal to give informed consent.

Data collection

After a detailed pre-anesthetic evaluation, patients were instructed to remain nil per oral as per ASA guidelines. Oral premedication included alprazolam 0.5 mg and ranitidine 150 mg, given the night before surgery. On the day of surgery, intravenous ranitidine 150 mg and metoclopramide 10 mg were administered 30 min before induction, following IV cannulation.

In the preoperative area, standard monitoring was initiated using pulse oximetry, electrocardiogram, non-invasive blood pressure, and capnography. Baseline vital signs were recorded and continuously observed for any intraoperative variations.

Premedication in the operating room included midazolam (0.02 mg/kg), glycopyrrolate (0.2 mg), and fentanyl (1–2 μg/kg). After 3 min of preoxygenation with 100% oxygen, induction was done using propofol (1–2.5 mg/kg). Adequate depth of anesthesia was confirmed by jaw relaxation and lack of response to verbal commands. Vecuronium (0.08 mg/kg) was administered for muscle relaxation.

The choice of SAD was based on the patient's weight and manufacturer's recommendations. Each device was checked for damage or leaks before insertion and lubricated with water-based jelly.

For the Blockbuster LMA, 20 mL of air was used for cuff inflation. Oropharyngeal seal pressure (OSP) was measured using a closed circuit at 3 L/min fresh gas flow, with auscultation to detect air leak sounds.

For BM insertion, the mouth was gently opened, and the device guided along the hard palate while avoiding the tongue. Placement was confirmed by bilateral chest rise, equal air entry, square-wave capnograph, stable end-tidal carbon dioxide, and oxygen saturation (SpO_2) >95%. The device was then secured with adhesive tape.

Anesthesia maintenance included oxygen, nitrous oxide, and sevoflurane, with intermittent vecuronium boluses (0.2 mg/kg). At the end of surgery, reversal was achieved using neostigmine and glycopyrrolate. The device was removed once the patient regained consciousness and showed adequate muscle power.

Ease of insertion was graded on a scale of 1–3. A fiberoptic scope (3.1 mm) was used to assess vocal cord visualization. The time taken from mask removal to effective ventilation, the number of attempts, and success rates were recorded. A successful attempt required tidal volume ≥7 mL/kg and a square-wave capnogram.

In cases where insertion failed after three attempts, the procedure was abandoned, and ETI was performed. These cases were excluded from the study.

Complications such as sore throat, nausea, vomiting, bronchospasm, laryngospasm, and stridor were monitored at regular intervals - immediately post-operative, every 15 min for 2 h, then every 4 h for 8 h, followed by assessments at 6, 12, and 24 h.

Ethical considerations

Ethical approval was obtained, and the trial was registered with the Clinical Trials Registry of India (CTRI/2023/10/059364).

Statistical analysis

We entered the data into MS-Excel Office version 2021 and then analyzed it using SPSS version 25. Depending on the nature of the data, we presented the descriptive statistics as percentages, mean with standard deviation, or median with interquartile range. Depending on the normality and nature of the data, we performed statistical tests such as the Chi-square test, Fisher Exact test, independent t-test, and Mann–Whitney *U*-test. We deemed the data statistically significant if the significance level was <0.05. We conducted a normality test, specifically the Kolmogorov-Smirnov test, on all the parameters.

RESULTS

The demographic profiles of patients in both groups were comparable, with Group I and Group II each having 23 (36.50%) patients aged 18–30 years, while 32 (50.81%) and 30 (47.63%) were aged 30–44 years, and 8 (12.69%) and 10 (15.87%) were aged 45–60 years, respectively. ASA Grade I status was observed in 35 (55.55%) in Group I and 33 (52.38%) in Group II, with the remaining patients being ASA Grade II; no statistically significant difference was noted (P>0.05) (Table 1). Regarding insertion characteristics, a single attempt was sufficient in 36 (57.14%) cases in Group I and 40 (63.49%) in Group II, while two attempts were needed in 22 (34.92%) and 20 (31.74%) cases, and >2 attempts in 5 (13.34%) and 3 (4.77%), respectively. Insertion time <30 s was recorded in 42 (66.66%) of Group I and 45 (71.42%) of Group II patients. The OLP was significantly higher in Group II (28.8±1.9 cmH_2O) compared to Group I (25.2±1.3 cmH_2O), with P=0.001 indicating better seal with Blockbuster LMA (Table 2). Ease of insertion grading showed that Grade 1 was achieved in 56 (88.88%) and 55 (87.30%) patients in Group I and II, respectively; Grade 2 in 5 (7.94%) and 6 (9.52%), and Grade 3 in 2 (3.18%) each, with no significant difference (P=0.951) (Table 3). Fiberoptic view (FOv) assessment revealed that Grade 1 view was achieved in 2 (3.17%) patients in Group I and 8 (12.69%) in Group II; Grade 2 in 16 (25.39%) and

Table 1: Demographic data of the participants (n=126)

Parameters	Group I (n=63) n (%)	Group II (n=63) n (%)	Chi-square	P-value
Age categories (in years)				
18–30	23 (36.50)	23 (36.50)	0.286	0.866
30–44	32 (50.81)	30 (47.63)		
45–60	8 (12.69)	10 (15.87)		
ASA Status				
I	35 (55.55)	33 (52.38)	0.11	0.74
II	28 (44.44)	30 (47.62)		

Table 2: Parameters related to insertion characteristics of the SAD (n=126)

Parameters	Group I (n=63)	Group II (n=63) (%)	Chi-square	P-value
Number of attempts				
1	36 (57.14)	40 (63.49)	0.805	0.668
2	22 (34.92)	20 (31.74)		
>2	5 (13.34)	3 (4.77)		
Time for insertion of the device (in seconds)				
<30	42 (66.66)	45 (71.42)	0.36	0.835
30-50	19 (30.15)	16 (25.39)		
>50	2 (3.19)	2 (3.19)		
Mean±OLP (oropharyngeal leak pressure) (in cmH_20)	25.2±1.3	28.8±1.9	4.812	0.001

SAD: Supraglottic airway devices, OLP: Oropharyngeal leak pressure

15 (23.80%), Grade 3 in 19 (30.15%) and 26 (41.26%), and Grade 4 in 26 (41.29%) and 14 (22.25%), respectively, with statistical significance (P=0.039) suggesting better glottic visualization with Blockbuster LMA (Table 4). Adverse events showed device displacement in 11 (17.46%) patients in Group I and 5 (7.93%) in Group II, blood staining in 4 (6.34%) and 6 (20.00%), sore throat in 5 (7.93%) and 4 (6.34%), hoarseness and mucosal injury were equal in both groups (1 [5.88%] each), with statistically significant difference in displacement (P=0.039) favoring Blockbuster LMA (Table 5). Hemodynamic parameters and SpO_2 levels recorded at various perioperative time points (during, after insertion, intraoperative, at removal, and postoperative) showed no statistically significant difference between the groups in heart rate (HR) (P>0.05 at all-time points), systolic and diastolic blood pressure, and SpO_2, indicating both devices maintained stable vital parameters throughout the surgical procedure (Table 6).

DISCUSSION

ETI has traditionally been the preferred method. However, the use of SADs has significantly impacted modern anesthetic practice, offering a less invasive alternative with reduced hemodynamic stress during placement, particularly in laparoscopic surgeries.[12]

The present study was a prospective randomized controlled trial comparing the utility of two SADs, Blockbuster LMA and BM, for general anesthesia in laparoscopic cholecystectomy at M.L.B. Medical College, Jhansi (U.P.). The study was conducted from May 2023 to May 2024 in collaboration with the Department of Surgery. No studies have compared these two devices during laparoscopic cholecystectomy.

In this study, the Blockbuster LMA demonstrated a higher first-attempt success rate (63.49%) compared to the BM (57.14%), although this difference was not statistically significant (P>0.05). Some studies have reported that the Blockbuster LMA can achieve first-pass success rates exceeding 90%.[13] The superior success of intubation with the Blockbuster LMA can be attributed to its favorable anatomical design, which enhances alignment with the oropharyngeal curve. The airway tube is angled at more than 95 degrees and is relatively short, facilitating proper positioning. Additionally, the Parker flex feature, with its inverted tip, reduces the risk of the tube contacting the anterior tracheal wall during insertion. This thoughtful design allows for smoother navigation along the airway, with the angle of emergence from the cuff being approximately 30°, as highlighted by Su et al.[14]

In our study, the success rate for device insertion was 96.92% for both the Blockbuster LMA and the BM. This finding aligns with the results of a previous study by Endigeri et al.,[15] which also reported a similar success rate for device insertion between the Fastrach LMA and the Blockbuster LMA. In contrast, Alexiev et al.,[16] noted a higher first-attempt success rate of 73% for the BM when compared to other SADs used in gynecological procedures.

When OLP values exceed peak airway pressure (PAP) values, effective airway maintenance without leakage is ensured. During laparoscopic surgery, intra-abdominal pressure increases by an average of 15 mmHg, causing PAP to rise by about 50% and leading to a decrease in lung compliance (approx. 25%). Consequently, laparoscopic surgeries result

Table 3: Distribution of participants according to ease of insertion scale (n=126)

Insertion scale grading	Group I (n=63) n (%)	Group II (n=63) n (%)	Chi-square	P-value
Grade 1	56 (88.88)	55 (87.30)	0.099	0.951
Grade 2	5 (7.94)	6 (9.52)		
Grade 3	2 (3.18)	2 (3.18)		

Table 4: Distribution of participants according to fiberoptic view (FOV) of the larynx (n=126)

FOV grading	Group I (n=63) (%)	Group II (n=63) (%)	Chi-square	P-value
FOV 1	2 (3.17)	8 (12.69)	8.321	0.039
FOV 2	16 (25.39)	15 (23.80)		
FOV 3	19 (30.15)	26 (41.26)		
FOV 4	26 (41.29)	14 (22.25)		

Table 5: Adverse effects (n=126)

Side effects	Group I (n=63)	Group II (n=63)	Chi-square	P-value
Displacement	11 (17.46)	05 (7.93)	8.321	0.039
Blood staining	04 (6.34)	06 (20.00)		
Sore throat	05 (7.93)	04 (6.34)		
Hoarseness	01 (5.88)	01 (5.88)		
Injury	01 (5.88)	01 (5.88)		

Table 6: Comparison of hemodynamic parameters and oxygen saturation between groups at various perioperative time points (n=126)

Parameters	Group I (n=80)	Group II (n=80)	P-value
Heart rate			
During	90.02±5.51	89.89±5.21	0.621
After	88.44±6.11	90.12±5.11	0.110
Intraoperative	87.40±6.12	87.99±4.19	0.143
Removal	89.22±5.27	87.11±5.19	0.250
Postoperative	89.89±6	88.81±6.23	0.468
Systolic blood pressure (SBP)			
During	119.66±7.80	121.33±6.09	0.401
After	121.66±2.90	120.27±3.04	0.340
Intraoperative	122.105±5.10	123.01±4.45	0.210
Removal	124.11±3.10	126.44±2.80	0.413
Postoperative	106.29±3.34	83.22±2.04	0.670
Diastolic blood pressure (DBP)			
During	79.000±6.63	81.000±7.10	0.682
After	80.010±6.51	82.150±6.57	0.302
Intraoperative	79.367±6.68	81.667±6.98	0.710
Removal	79.167±6.16	79.667±6.66	0.410
Postoperative	78.153±6.98	79.963±6.22	0.209
S_PO_2			
During	98.82±0.51	98.623±0.91	0.282
After	99.24±0.41	98.94±0.21	0.489
Intraoperative	99.60±0.02	98.78±0.69	0.708
Removal	98.22±0.27	98.92±0.89	0.890
Postoperative	97.89±0.60	98.19±0.23	0.103

SPO2: Oxygen saturation

in less favorable ventilatory conditions compared to general operations with lower PAPs. Based on the findings, it may be advisable to consider SAD over PAP for laparoscopic surgery due to its higher OLP value. The OLP of the Blockbuster LMA was 28.8±1.9 cm H_2O, higher than that of the Blockbuster LMA (25.2±1.3 cm H_2O). This difference was statistically significant (P<0.00001). Endigeri et al.,[15] found that the Blockbuster LMA resulted in higher oropharyngeal pressure (33.7±1.8 cm H_2O) compared to the Fastrach LMA (22.7±1.5 cm H_2O), with a statistically significant P<0.05.

In our study, we compared the ease of insertion between two devices. Both devices demonstrated a similar level of ease of insertion, and our analysis revealed no statistically significant difference between them. In a study conducted by Khare et al.,[17] the insertion of the Blockbuster LMA was easier and required less skill compared to the I-gel, with statistically significant results (P<0.001). Alexiev et al.,[16] found that inserting the BM was more challenging than the classical laryngeal mask.

The FOV grading shows that the Blockbuster LMA achieves more Grade 1 views than the BM, this implies that the Blockbuster LMA typically provides a clearer, more optimal view of the laryngeal structures, with a statistically significant P<0.05. Similarly, Raman et al.,[18] observed comparable FOV grading between the groups using the BM and the Ambu Aura Gain (AAG), with the glottis visible in more than 90% of cases. Wang et al.,[19] reported that visualization of the glottis through LMA was significantly improved with the use of Blockbuster® LMA.

During the study, the mean HR, mean blood pressure and mean SpO_2 levels changed similarly for both devices, with no statistical significance (P>0.05). Throughout the procedure, no significant differences were noted between the groups in terms of mean arterial pressure (MAP) and mean S_pO_2. Our study was like a study done by Kaur et al.,[20] who also observed no significant differences in HR, MAP, and SpO_2 when comparing Blockbuster LMA and ILMA at various time intervals.

In cases involving the BM group, the device often experienced displacement, unlike the Blockbuster LMA, due to 4-way connector. All other complications, such as blood staining, sore throat, hoarseness, and injury, were similar in both groups.

Our study found that none of the groups experienced desaturation, bronchospasm, change in voice, gastric distension, aspiration, or lip/tongue or dental injury. According to a study by Raman et al.,[18] participants experienced a higher frequency of cough and sore throat with the AAG compared to the BM as indicated by statistical analysis. The cuff of the BM inflates only during inspiration, ensuring that pressure on peri-laryngeal tissues is limited to peak inspiratory pressure, providing comfort and safety. This design eliminates the risk of increased cuff pressure during surgery due to nitrous oxide diffusion into the mask's cuff.

The strengths of our study include its randomized study design with a significant sample size, allowing for reliable comparisons. Conducted in a specialized care facility, ensuring consistent monitoring and high procedural standards. First study in our country comparing these two devices for laparoscopic cholecystectomy.

One potential limitation of the study is that it was conducted at a single center and only involved single blinding. Further investigation on the same subject can be conducted across various institutions to obtain a more diverse sample. This is important because relying solely on data from a single center may introduce bias and limit the applicability of the findings to other tertiary care institutes in India.

Limitations of the study

The study's limitations include its single-center design, small sample size, and single blinding, which may limit generalizability and introduce potential bias.

CONCLUSION

Both SAD, namely the Blockbuster LMA and the BM, can be safely used during general anesthesia and positive pressure ventilation for laparoscopic cholecystectomy. The Blockbuster LMA has a shorter insertion time compared to the BM with better OSP. Complications such as displacement, sore throat, and blood staining are less common with the Blockbuster LMA. There is no significant difference between the two devices in terms of ease of insertion and hemodynamic changes during the perioperative period. The BM has the added advantage of an inbuilt "tab" that facilitates its insertion, as well as a gastric reflux high-flow suction system for the clearance of gastric fluids and pharyngeal secretions. The Blockbuster LMA has the advantage of gastric channel access, intubating options, and a 4-way connector for secure fixation of the LMA.

RECOMMENDATIONS

Based on the findings of this study, both the Blockbuster LMA and BM are safe and effective SAD for laparoscopic cholecystectomy under general anesthesia. However, due to its shorter insertion time, higher OSP, and fewer complications, the Blockbuster LMA may be preferred in clinical practice. Further multicentric, double-blind studies with larger sample sizes are recommended to validate these results and explore device performance in high-risk surgical patients.

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