

Comparison of The Clinical Performance of The LMA Supreme, LMA ProSeal And Ambu AuraGain in Paediatric Patients Undergoing Elective Surgery Under General Anaesthesia: A Prospective, Randomised study

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ABSTRACT

Background: Second-generation supraglottic airway devices (SADs) provides effective airway management with better sealing, gastric drainage and reduced airway-related complications. LMA ProSeal, LMA Supreme, and Ambu AuraGain differ in design and clinical performance; however, comparative evidence in paediatric patients remains limited and aim of our study was to compare the clinical performance of these three second-generation SADs in paediatric patients under controlled ventilation.

Methods: This prospective, randomized study included 105 paediatric patients, 6 months-8 years age, ASA physical status I-II undergoing elective surgery under general anaesthesia. Participants were randomly allocated to receive Ambu AuraGain (n=35), LMA ProSeal (n=35) or LMA Supreme (n=35). The primary outcome was oropharyngeal leak pressure (OLP) measured immediately after insertion and at 10 minutes. Secondary outcomes included insertion time, first-attempt insertion success, ease of insertion, requirement for airway manoeuvres, gastric tube insertion, haemodynamic and respiratory parameters, and perioperative complications. Data were analysed using ANOVA, Kruskal-Wallis, Chi-square, or Fisher's exact tests, with $p < 0.05$ considered statistically significant.

Results: Baseline demographic characteristics were comparable among the three groups ($p > 0.05$). LMA Supreme (11.99 ± 3.31 s) and Ambu AuraGain (12.78 ± 3.04 s) demonstrated significantly shorter insertion times than LMA ProSeal (21.85 ± 4.68 s) ($p < 0.001$). Grade I insertion was achieved more frequently with LMA Supreme (94.3%) and Ambu AuraGain (88.6%) than with LMA ProSeal (62.9%) ($p = 0.016$), and fewer airway manoeuvres were required ($p = 0.006$). Ambu AuraGain produced significantly higher OLP both immediately after insertion (24.93 ± 3.16 cmH₂O) and at 10 minutes (26.29 ± 3.41 cmH₂O) compared with LMA ProSeal (20.76 ± 4.37 and 21.81 ± 4.49 cmH₂O) and LMA Supreme (20.52 ± 3.01 and 22.02 ± 3.32 cmH₂O) (both $p < 0.001$). First-attempt device insertion and gastric tube insertion success were comparable among groups ($p = 0.159$ and $p = 0.608$, respectively). Haemodynamic, respiratory parameters and perioperative complications were not significantly different between groups.

Conclusion: All three second-generation supraglottic airway devices provided safe and effective airway management in paediatric patients. Ambu AuraGain demonstrated superior airway sealing, whereas LMA Supreme offered the fastest and easiest insertion. Both Ambu AuraGain and LMA Supreme are therefore recommended as superior alternatives to LMA ProSeal for routine paediatric airway management.

Keywords: Ambu AuraGain; LMA ProSeal; LMA Supreme; Oropharyngeal leak pressure, Paediatric anaesthesia

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INTRODUCTION

Airway management is a critical component of paediatric anaesthesia because children have distinct anatomical and physiological characteristics that predispose them to rapid oxygen desaturation during periods of inadequate ventilation. Compared with adults, paediatric patients have a higher metabolic rate,

increased oxygen consumption, lower functional residual capacity, and a relatively narrower airway, making effective airway management essential for preventing perioperative hypoxia and its complications.¹⁻³

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Supraglottic airway devices (SADs) have become widely accepted alternatives to endotracheal intubation for elective surgical procedures requiring general anaesthesia. Compared with tracheal intubation, SADs are associated with easier placement, reduced airway stimulation, attenuated haemodynamic responses, lower incidence of postoperative airway morbidity and faster recovery. The introduction of second-generation SADs, incorporating gastric drainage channels and improved cuff designs, has further enhanced airway sealing and reduced the risk of gastric insufflation and pulmonary aspiration, thereby facilitating their use during controlled mechanical ventilation.⁴⁻⁶

Among second-generation SADs, the LMA ProSeal, LMA Supreme, and Ambu AuraGain are commonly used in paediatric anaesthesia. Although all these devices provide effective ventilation and gastric access, they differ in design, insertion characteristics and airway sealing capability. Oropharyngeal leak pressure (OLP) is considered one of the most important indicators of SAD performance because it reflects the quality of the airway seal and the ability to maintain positive pressure ventilation without gas leakage.^{7,8}

Despite the widespread use of these devices, comparative evidence evaluating their clinical performance in paediatric patients remains limited. Therefore, this study was conducted to compare the LMA ProSeal, LMA Supreme, and Ambu AuraGain in paediatric patients undergoing elective surgery under general anaesthesia. The primary objective was to compare oropharyngeal leak pressure, while secondary objectives were insertion characteristics, ease of gastric tube placement, haemodynamic and ventilation parameters, and perioperative airway-related complications.

MATERIALS AND METHODS

After approval from the Institutional Ethics Committee this prospective, randomized study was conducted in the tertiary care hospital in Rajkot from May 2024 and December 2025 (CTRI/2025/04/084153). A total of 105 paediatric patients aged 6 months to 8 years, either sex, weighing 5–30 kg, with American Society of Anaesthesiologists (ASA) physical status I or II, scheduled for elective surgical procedures under controlled ventilation in supine position with an expected duration of less than 120 minutes were included. The study adhered to the ethical principles of the Declaration of Helsinki and written informed consent was obtained from the parents or legal guardians of all participants before enrolment. Patients with anticipated difficult airway, active upper respiratory tract infection, cardiopulmonary disease, any systemic disease, increased risk of aspiration, congenital airway abnormalities, allergy to device materials, or refusal of parental consent were excluded. Participants were randomly allocated in three groups LMA ProSeal (n= 35), LMA Supreme (n=35), or Ambu AuraGain (n=35). Randomisation was done using a computer-generated randomization sequence.

Allocation concealment was maintained using sequentially numbered opaque sealed envelopes. The study was single-blinded, with patients unaware of the allocated device. All insertions were performed by anaesthesia trainees with a prior experience of at least 20 successful insertions of each of the device under the supervision of senior anaesthesiologist to minimize variation. For all three devices i.e. LMA Proseal, LMA Supreme, Ambu AuraGain, the device sizes used were 1.5 (5-10kg), 2(10-20kg), and 2.5(20-30kg).

Standard fasting guidelines (8h for solid food, 4h for milk and 2h for clear water) were followed before surgery. Routine monitoring included electrocardiography, non-invasive blood pressure, pulse oximetry and capnography. Glycopyrrolate (0.004 mg/kg) and fentanyl (1 µg/kg) were administered as premedication after intravenous access. After preoxygenation with 100% oxygen for 3 minutes, general anaesthesia was induced under sevoflurane followed by intravenous propofol (2 mg/kg). An appropriately sized SAD was selected according to the manufacturer's weight-based recommendations, cuff of SADs were deflated and lubricated with watery jelly before insertion. The patient should be in the “sniffing air” position with the tip of the cuff is pressed upward against the hard palate by the index finger while the middle finger opens the mouth. The SADs is advanced until definite resistance is felt. Correct placement was confirmed by bilateral chest expansion, square-wave capnography, equal breath sounds on auscultation, and effective positive-pressure ventilation. Anaesthesia was maintained with sevoflurane (1.5-2%) in oxygen and nitrous oxide, and controlled mechanical ventilation was instituted following administration of atracurium (0.5 mg/kg). Time for successful insertion of the device was measured from the removal of the face mask until bilateral chest rise with the first capnogram upstroke is noted. The number of attempts required for successful device placement was recorded as first attempt, second attempt, third attempt, or not able to place. A maximum of three attempts of the same device with different size was allowed. After three unsuccessful device insertion tracheal intubation was planned. Ease of placement of device was assessed using a subjective scale of 1–4 (1= no resistance, 2 = mild resistance, 3 = moderate resistance, 4 = inability to place the device). After 3 unsuccessful attempts of insertion of device, it was considered as failure to insert the device. If ventilation was inadequate requirement for airway manoeuvres during device placement was assessed using a three-point scale. Grade 1 – Easy (no manoeuvre required for insertion), Grade 2– Difficult (one manoeuvre required for insertion), and Grade 3 – Very Difficult (more than one manoeuvres for insertion). The manoeuvres included adjustment of head and neck position, gentle modification in the depth of insertion, application of jaw lift and gentle chin traction. Proper placement was confirmed by auscultation and insertion of lubricated nasogastric tube through the gastric tube channel. Ease of insertion of gastric tube was based on a scale, Grade

1- easy (1st attempt), Grade 2- Difficult (2nd attempt) and Grade 3- unable to insert, confirmation of appropriate placement of the tube is done by aspiration of gastric contents with 10 ml syringe.

Anaesthesia was maintained with an end tidal sevoflurane concentration of 1.5-2, oxygen and nitrous oxide 60-40 %. Inj. Atracurium 0.5mg/kg given after confirmation of correct placement of device, all the patients were ventilated with controlled mechanical ventilation with Spo2 maintained more than 95% and Etco2 between 35-45 mm Hg.

Oro-pharyngeal Leak Pressure(OLP) is assessed immediate and after 10 min of positioning (OLP difference) and fixation of the device. It was measured by palpable or audible leak of gas in suprasternal notch and auscultation of epigastrium after closing the expiratory valve of the circle system to 30 cm of H2O at a fixed gas flow (only O2) of 3 L/min and airway pressure at steady state noted on visual pressure gauge included in modern anaesthesia machine. A maximum pressure of 30 cm of H2O is permitted.

Vital parameters like heart rate, blood pressure (SBP, DBP), SpO2 and EtCO2 were monitored and noted before induction of anaesthesia, immediately after insertion of device and at 5, 10, 20, 30, 45, 60 and 90min throughout surgery till patient was extubated. After completion of surgery, inhalation agent and N2O was stopped and patient was reversed with inj. Neostigmine 0.05 mg/kg and inj. Glycopyrrolate 0.01 mg/kg intravenously, when patient's spontaneous respiration returned. Inj. Paracetamol (PCM) 15mg /kg was supplemented at the end of surgery. Device removed after fulfilment of criteria for removal of airway device. Any adverse events/complications like bronchospasm, laryngospasm, aspiration, hypoxia (Oxygen saturation <90%), blood staining on device, dental trauma, nausea, vomiting, coughing, hiccup and regurgitation were

observed and noted during intraoperative and postoperative period. Patients were shifted to post anaesthesia care unit (PACU) for postoperative observation.

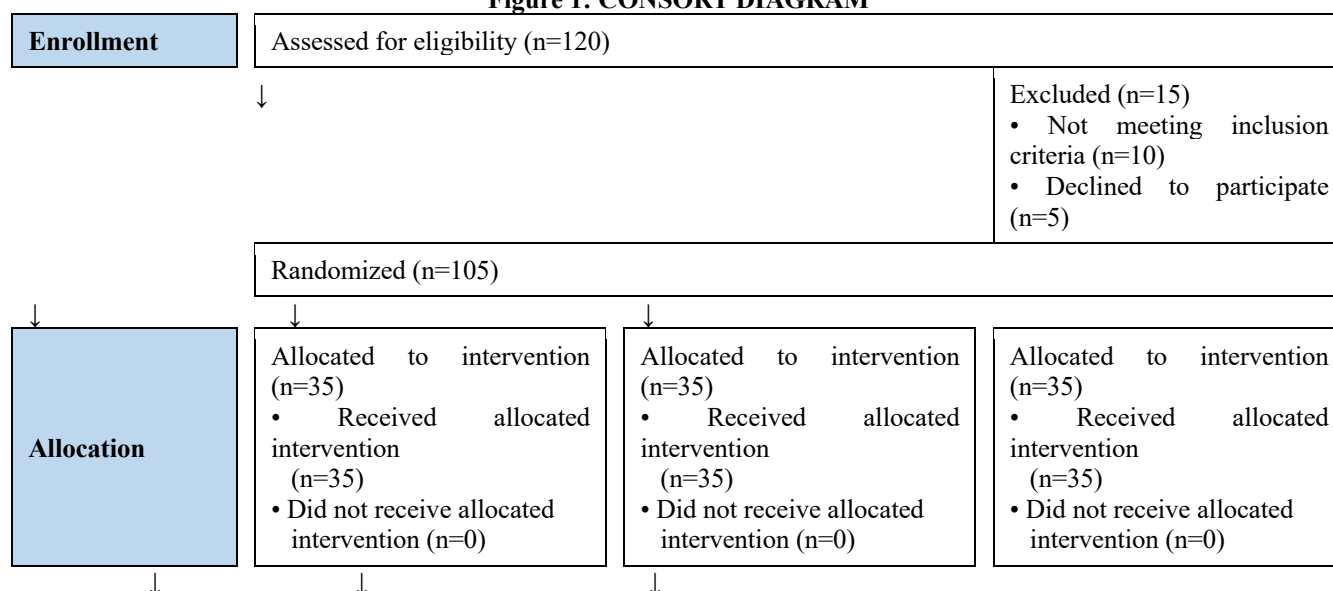
The primary outcome was oropharyngeal leak pressure (OLP), measured immediately after device insertion and again after 10 minutes using a standardized leak test. Secondary outcomes included insertion success rate, insertion time, ease of insertion, requirement for airway manoeuvres, ease of gastric tube insertion, haemodynamic variables (heart rate, systolic and diastolic blood pressure), respiratory variables (SpO2 and end-tidal carbon dioxide), and perioperative complications.

Sample size was calculated with reference to previous studies⁹⁻¹⁰, that revealed oropharyngeal leak pressures for Ambu AuraGain is higher than LMA Supreme (27.5±7.7 cmH2O 24.5±4.1 cmH2O respectively), the minimum required sample size with power 80% and 5% level of significance was 30 patients in each group. To compensate for 10% dropouts, 35 patients were enrolled in each group, resulting in a total sample size of 105 patients.

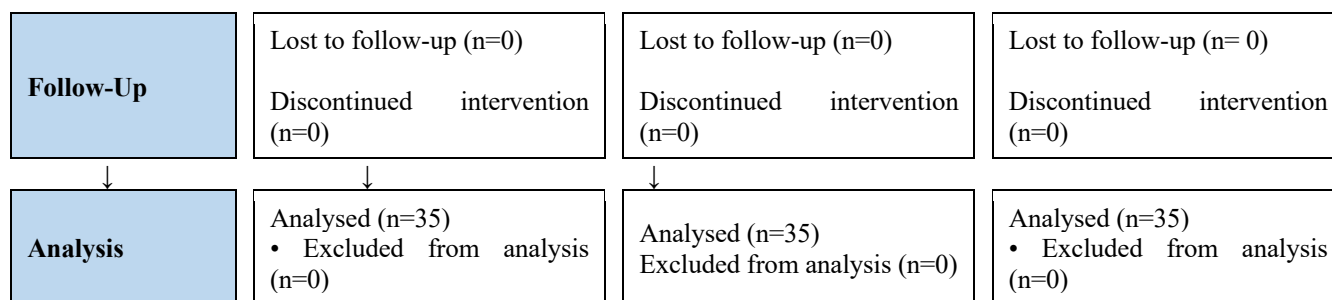
Statistical analysis was performed using JAMOV version 2.7. Continuous variables were expressed as mean ± standard deviation or median (interquartile range), depending on data distribution, while categorical variables were presented as frequencies and percentages. Intergroup comparisons were performed using one-way analysis of variance (ANOVA) for normally distributed variables, the Kruskal–Wallis test for non-parametric variables, and the Chi-square test or Fisher's exact test for categorical variables. Tukey's post-hoc test or Mann–Whitney U test was used for pairwise comparisons where appropriate. A two-sided p value <0.05 was considered statistically significant.

RESULTS

Figure 1: CONSORT DIAGRAM



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The three groups were comparable with respect to age, sex, weight, height, body mass index, ASA physical status, type of surgery (Table 1). Ambu AuraGain demonstrated significantly higher oropharyngeal leak pressure than LMA ProSeal and LMA Supreme both immediately after insertion (24.93 ± 3.16 vs. 20.76 ± 4.37 and 20.52 ± 3.01 cmH₂O, respectively; $p < 0.001$) and at 10 minutes (26.29 ± 3.41 vs. 21.81 ± 4.49 and 22.02 ± 3.32 cmH₂O, respectively; $p < 0.001$). The increase in leak pressure over the first 10 minutes was comparable among the three groups ($p = 0.118$) (Table 2).

The median device size used was 2.0 in all groups, with no significant intergroup difference ($p = 0.771$) (Table 4). Insertion time differed significantly among the three devices (ANOVA, $p < 0.001$). LMA Supreme (11.99 ± 3.31 s) and Ambu AuraGain (12.78 ± 3.04 s) required significantly less insertion time than LMA ProSeal (21.85 ± 4.68 s). First-attempt insertion was successful in 91.4% of patients in both the Ambu AuraGain and LMA Supreme groups compared with 74.3% in the LMA ProSeal group; however, this difference was not statistically significant ($p = 0.159$). Ease of placement differed significantly among the groups ($p = 0.016$). Grade 1 placement (no resistance) was achieved in

94.3% of the LMA Supreme group, 88.6% of the Ambu AuraGain group, and 62.9% of the LMA ProSeal group. Similarly, the requirement for airway manoeuvres was significantly lower with LMA Supreme 94.3% and Ambu AuraGain 88.6% than with LMA ProSeal 62.9% ($p = 0.006$.) Successful first-attempt gastric tube insertion was achieved in 88.6% of patients in the Ambu AuraGain group, 85.7% in the LMA Supreme group, and 80.0% in the LMA ProSeal group, with no statistically significant difference among the groups ($p = 0.608$). The incidence of perioperative complications was low in all three groups. Heart rate, systolic blood pressure, diastolic blood pressure, oxygen saturation (SpO₂), and end-tidal carbon dioxide (EtCO₂) remained comparable among the three groups throughout the intraoperative period, with no statistically significant differences at any time point (all $p > 0.05$) (Figures 2–4).

Minor complications, including blood staining of the device, transient hypoxia, retching, laryngospasm, bronchospasm, and regurgitation, occurred infrequently, with no significant difference between groups (all $p = 1.000$). No cases of aspiration, dental trauma, coughing, or hiccups were observed. (Table 4).

Table 1. Baseline demographic and clinical characteristics

Variable	Ambu AuraGain (n=35)	LMA ProSeal (n=35)	LMA Supreme (n=35)	P value
Age (months), Median (IQR)	43 (20.5–70.5)	47 (22.5–74.5)	37 (14.0–78.0)	0.653
Male	18 (51.4)	18 (51.4)	16 (45.7)	0.859
Female n (%)	17 (48.6)	17 (48.6)	19 (54.3)	
Weight (kg), Median (IQR)	15.2 (11.0–19.4)	15.8 (11.4–20.1)	14.2 (8.9–20.4)	0.653
Height (cm), Median (IQR)	90.5 (78.3–103.3)	92.5 (79.6–105.6)	87.5 (71.8–106.1)	0.649
ASA I/II n (%)	21/14 (60.0)/(40.0)	25/10 (71.4)/(28.6)	18/17 (51.4)/(48.6)	0.228
Surgical characteristics				
General surgery, n (%)	17 (48.6)	18 (51.4)	15 (42.9)	
Orthopaedic surgery, n (%)	10 (28.6)	8 (22.9)	12 (34.3)	0.885
Plastic surgery, n (%)	8 (22.9)	9 (25.7)	8 (22.9)	

Data are presented as median (IQR) or number (%).

Table 2. Oropharyngeal leak pressure

Parameter	Ambu AuraGain	LMA ProSeal	LMA Supreme	P value
Immediate OLP (cmH ₂ O)	24.93 ± 3.16	20.76 ± 4.37	20.52 ± 3.01	<0.001
OLP at 10 min (cmH ₂ O)	26.29 ± 3.41	21.81 ± 4.49	22.02 ± 3.32	<0.001
OLP difference, Median (IQR)	1.0 (1.0)	1.0 (2.0)	1.0 (1.0)	0.118

Values expressed as Mean $\pm$ SD, p-value by one-way ANOVA. $p < 0.05$ considered statistically significant.

OLP difference, Values expressed as Median (IQR). p-value by Kruskal-Wallis test ($H = 4.279$, $df = 2$). $p \geq 0.05$ = not

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statistically significant.

Table 3: Insertion characteristics

Variable	Ambu AuraGain (n=35)	LMA ProSeal (n=35)	LMA Supreme (n=35)	P value
Size of the device, Mean±SD	2.03±0.27	2.06 ±0.36	2.00 ±0.36	0.771
Size 1.5	4(11.4)	3 (8.6)	5(14.3)	
Size 2.0	27(77.1)	24(68.6)	20(57.1)	
Size 2.5	4(11.4)	8(22.9)	10(28.6)	
Insertion time (s), Mean ± SD	12.78 ± 3.04	21.85 ± 4.68	11.99 ± 3.31	<0.001
Insertion Attempts, n (%)				
First Attempt	32(91.4)	26 (74.3)	32(91.4)	0.159
Second Attempt	3(8.6)	7(20)	3(8.6)	
Unable to insert	0(0.0)	2(5.7)	0(0.0)	
Ease of placement of device, n (%)				0.016
Grade 1 (No resistance)				
Grade 2(Moderate resistance)	31(88.6)	22 (62.9)	33(94.3)	
Grade 3 (High resistance)	3(8.6)	7(20.0)	2(5.7)	
Grade 4 (Unable to place)	1(2.9)	4(11.4)	0(0.0)	
	0(0.0)	2(5.7)	0(0.0)	
Airway manoeuvre required, n (%)				0.006
Easy (No manoeuvre)				
Difficult (1 manoeuvre)	31(88.6)	22 (62.9)	33 (94.3)	
Very Difficult (>1 manoeuvre)	3(8.6)	7(20.0)	2(5.7)	
	1(2.9)	6(17.1)	0(0.0)	
Gastric tube insertion				0.608
First-attempt success, n (%)	31 (88.6)	28 (80.0)	30 (85.7)	
Second attempt, n (%)	4 (11.4)	5 (14.3)	5 (14.3)	0
Failed insertion, n (%)	0	2 (5.7)		

Values expressed as Mean ± SD and *number (%)*.

Table 4: Intraoperative and Postoperative Complications by Device Type (N=105)

Complication	Ambu AuraGain (n=35)		LMA ProSeal (n=35)		LMA Supreme (n=35)		p value
	No.	%	No.	%	No.	%	
Blood on device	1	2.9	0	0.0	1	2.9	1.00
Laryngospasm	0	0.0	0	0.0	1	2.9	1.00
Bronchospasm	0	0.0	0	0.0	1	2.9	1.00
Regurgitation	0	0.0	0	0.0	1	2.9	1.00
Retching/Vomiting	1	2.9	0	0.0	0	0.0	1.00
Hypoxia (SpO ₂ <90%)	1	2.9	0	0.0	0	0.0	1.00
Coughing	0	0.0	0	0.0	0	0.0	NA
Hiccup	0	0.0	0	0.0	0	0.0	NA
Dental trauma	0	0.0	0	0.0	0	0.0	NA
Aspiration	0	0.0	0	0.0	0	0.0	NA

Values expressed as *number (%)*.

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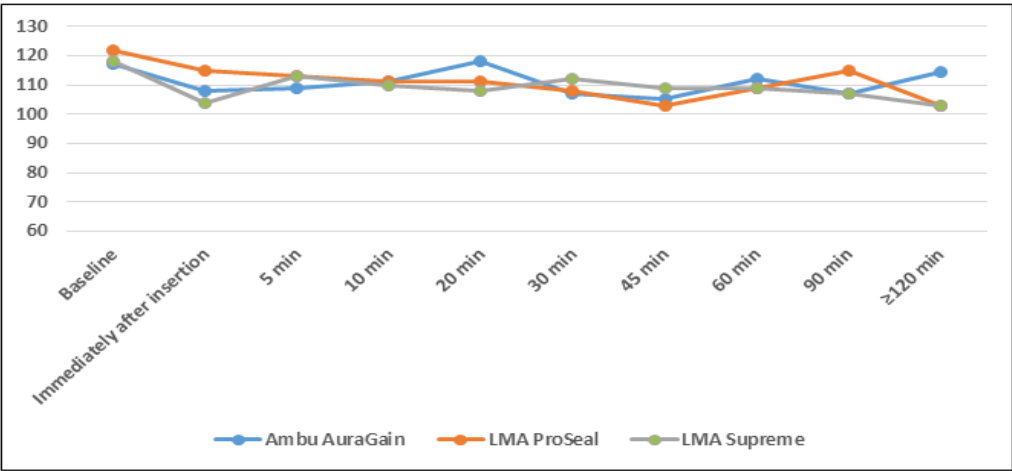


Figure 2: Comparison of Heart Rate (beats/min) at Various Time Points by Device Type (N=105)

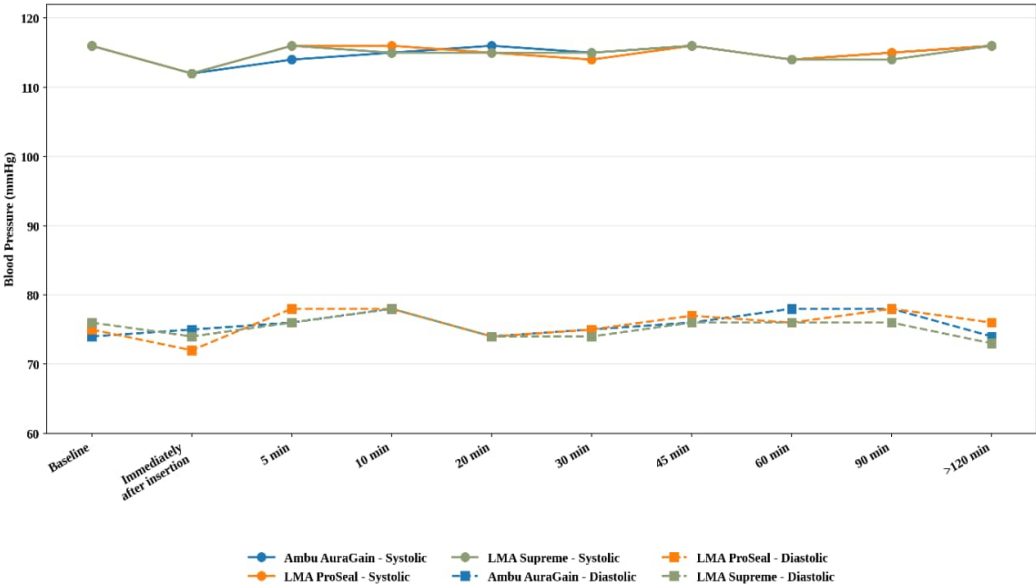


Figure 3: Comparison of Systolic Blood Pressure and Diastolic Blood Pressure (mmHg) at Various Time Points by Device Type (N=105)

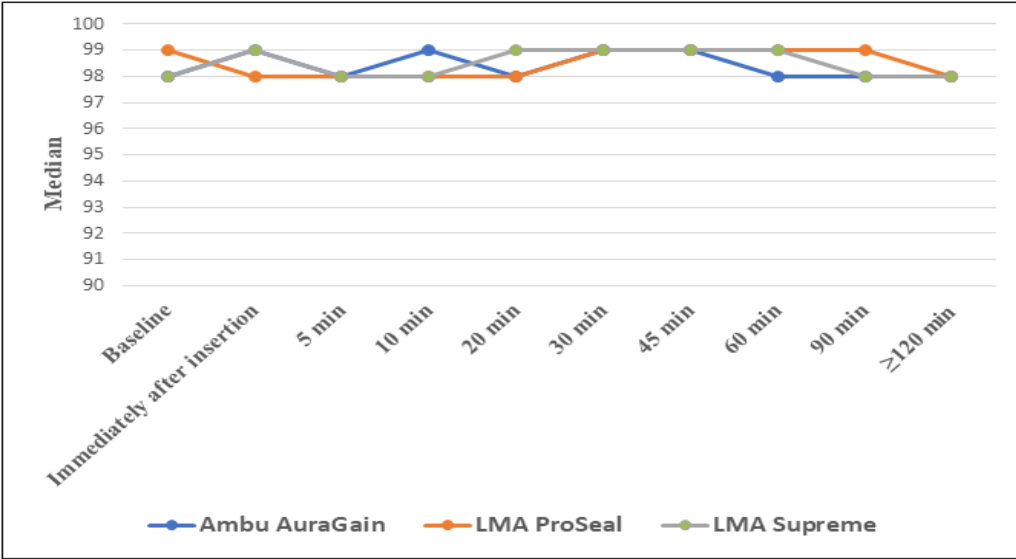


Figure 4: Comparison of SpO₂ (%) at Various Time Points by Device Type (N=105)

DISCUSSION

The present prospective randomized study compared the clinical performance of three second-generation SADs—Ambu AuraGain, LMA ProSeal, and LMA Supreme in paediatric patients undergoing elective surgery under general anaesthesia.

The primary outcome, oropharyngeal leak pressure is a significant determinant that features the efficiency of SADs. In our study, Ambu AuraGain had significantly higher values compared to both LMA ProSeal and LMA Supreme at immediate insertion (24.93 ± 3.16 cmH₂O versus 20.76 ± 4.37 and 20.52 ± 3.01 cmH₂O respectively, $p < 0.001$) and at 10 minutes (26.29 ± 3.41 cmH₂O versus approximately 22 cmH₂O for both, $p < 0.001$). All three devices exceeded the accepted minimum threshold of 20 cmH₂O for safe positive pressure ventilation, but Ambu AuraGain consistently provided the widest sealing margin which may be because of soft silicone cuff that seals naturally around the laryngeal inlet. LMA ProSeal has a double-cuff design a primary cuff around the laryngeal inlet and a smaller dorsal cuff at the back which works by pushing the primary cuff forward against the laryngeal opening to create a high seal pressure. Jagannath et al.¹¹ in his study reported no statistically significant differences in the initial and 10-min leak pressures between the AuraGain and LMA Supreme ($p = 0.4$ and $p = 0.08$, respectively) in infants and children. Theiler et al.¹², Drake-Brockman et al.¹³, and Kleine-Brueggene et al.¹⁴, also reported similar findings in their paediatric studies, and our results are in consonance with these studies.

The median increase in OLP from insertion to 10 minutes was 1.00 cmH₂O for all three groups, with no statistically significant difference between them. The better sealing pressures of Ambu AuraGain, present from the moment of insertion was simply maintained over 10 minute may be because of good initial positioning and cuff conformity rather than a slower settling process. Previous studies¹²⁻¹⁴ reported similar uniform OLP changes over time across device groups in their paediatric studies.

Although Ambu AuraGain provided superior airway sealing, LMA Supreme demonstrated significantly shorter insertion time and greater ease of insertion. These findings may be explained by its preformed anatomically curved airway tube, which facilitates rapid placement without the need for additional manoeuvres. Similar observations have been reported by Eschertzhuber et al.¹⁵ and Theiler et al.¹² who found that the LMA Supreme could be inserted faster than LMA ProSeal while maintaining comparable ventilation quality. The relatively longer insertion time observed with LMA ProSeal has been attributed to its softer cuff and the need for more precise placement, particularly when inserted using the digital technique.¹⁴⁻¹⁶

The first-attempt insertion success rate exceeded 90% with Ambu AuraGain and LMA Supreme and was slightly lower with LMA ProSeal, although the difference was not statistically significant. Previous

studies comparing second-generation supraglottic airway devices have similarly reported high first-pass success rates when devices are inserted by experienced anaesthesiologists, suggesting that all three devices provide reliable airway management in children undergoing elective surgery^{9,15,17}

Successful gastric tube placement was achieved in the majority of patients irrespective of device type, with no significant intergroup difference. The integrated gastric drainage channel incorporated into all three devices facilitates gastric decompression and may reduce gastric insufflation during positive-pressure ventilation. Comparable findings have been reported in previous paediatric studies evaluating second-generation supraglottic airway devices.^{12,18}

Haemodynamic variables and respiratory parameters remained stable throughout the perioperative period in all three groups. These findings are consistent with previous reports^{19,20} demonstrating that SADs produce minimal sympathetic stimulation compared with endotracheal intubation and therefore maintain cardiovascular stability during induction and maintenance of anaesthesia¹⁶.

The incidence of perioperative complications was low and comparable among the three groups. Minor events, including blood staining of the device, transient hypoxia, retching, laryngospasm, bronchospasm, and regurgitation, occurred infrequently, while no patient experienced aspiration or dental trauma. These findings support the favourable safety profile of second-generation supraglottic airway devices reported in previous systematic reviews and clinical studies.^{17,20,21}

Ambu AuraGain may be preferred when a higher airway seal is required, such as during controlled ventilation whereas LMA Supreme may be advantageous in situations requiring rapid and straightforward airway placement. LMA ProSeal continues to provide effective ventilation and gastric drainage and remains an alternative for routine paediatric airway management.

This study has several limitations. It was conducted at a single tertiary care centre with a relatively modest sample size, which may limit the generalizability of the findings and also blinding of the device was not possible because of the visible difference in size and design. We couldn't assess the Brimacombe score as pediatric fiberoptic was not available at our institution and the devices were also reused causing difference in oropharyngeal seal pressures. Future studies on pediatric patients with difficult airways undergoing elective surgery as well as utility in laparoscopic surgery should be conducted to evaluate the performance of these devices.

CONCLUSION

All three second-generation supraglottic airway devices studied Ambu AuraGain, LMA ProSeal, and LMA Supreme—are safe and effective for controlled ventilation in paediatric patients undergoing elective surgery. However, LMA Supreme and Ambu AuraGain

are significantly easier and faster to insert than LMA ProSeal, and Ambu AuraGain additionally provides the highest oropharyngeal leak pressure of the three. Both Ambu AuraGain and LMA Supreme are therefore recommended as superior alternatives to LMA ProSeal for routine paediatric airway management.

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