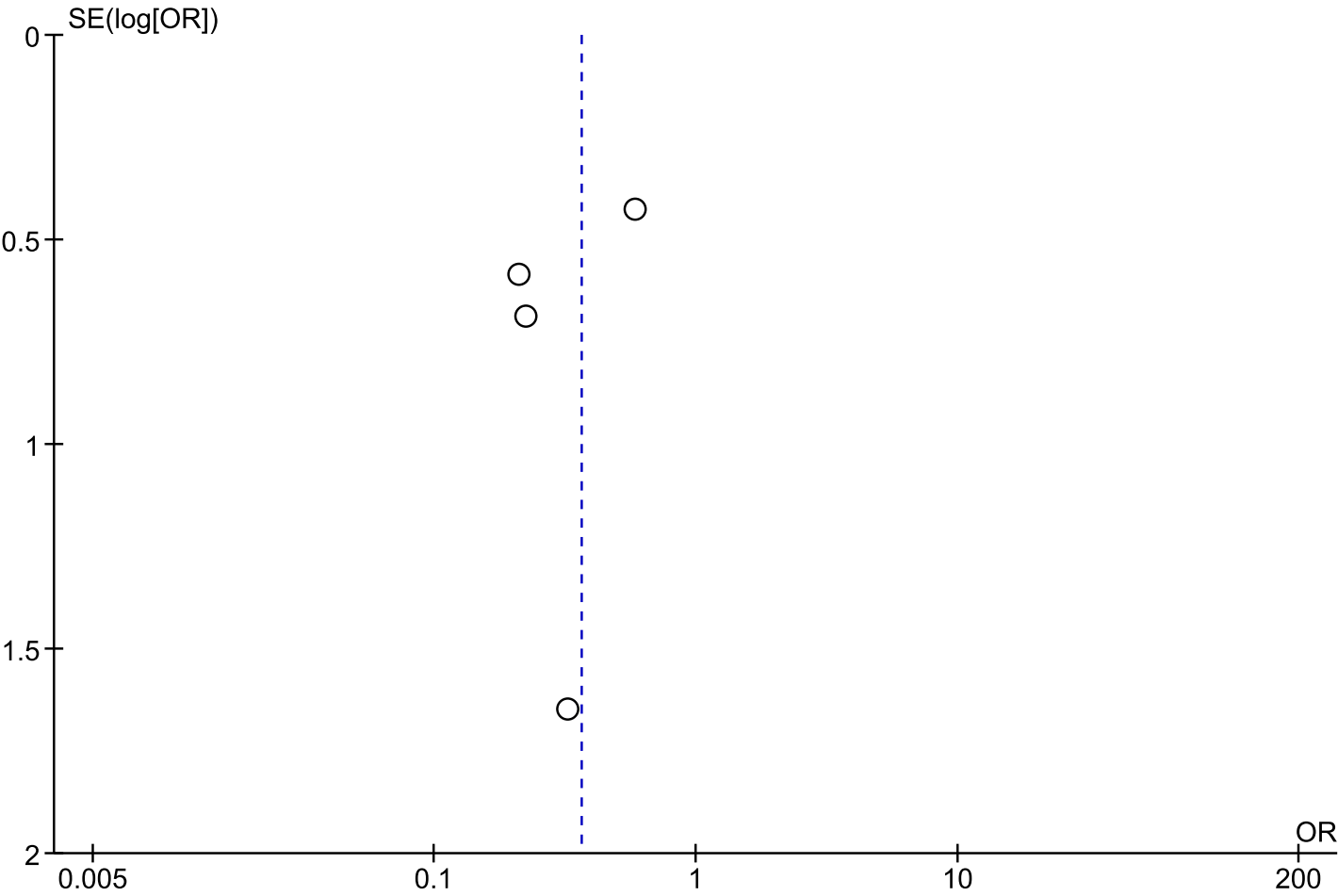
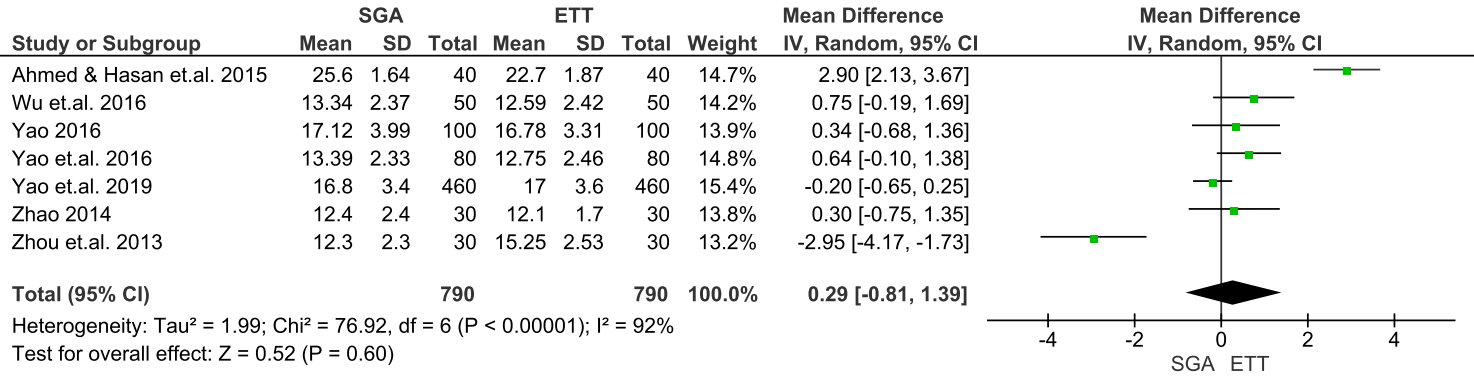


**Figure S1:** Funnel plot of sore throat with Supraglottic Airway versus Endotracheal Tube Intubation.



**Figure S2:** Peak airway pressures prior to delivery with Supraglottic Airway (SGA) versus Endotracheal Tube Intubation.



**Table S1:** Excluded studies.

Study	Rationale
Chung EJ, Yang HS, Suh BT. [Clinical Application of Laryngeal Mask Airway in Cesarean Section]. <i>Korean Journal of Anesthesiology</i> . 2000;39(6):6.	No endotracheal tube control group.
Francksen H, Bein B, Cavus E, et al. Comparison of LMA Unique, Ambu laryngeal mask and Soft Seal laryngeal mask during routine surgical procedures. <i>Eur J Anaesthesiol</i> 2007; 24: 134-140.	Non Cesarean Section (CS) patients studied.
Jiang D, Wang P. [Application value of sevoflurane-induced compound laryngeal mask general anesthesia in cesarean section]. <i>China Journal of Pharmaceutical Economics</i> . 2018;2:100-102.	No outcomes of interest.
Guo S., Liu X., Zhou T., M. Z. Application of sevoflurane inhalation general anesthesia under laryngeal mask in cesarean section of pregnant	No outcomes of interest.

women with heart disease. <i>Jiangxi Medicine</i> . 2015(7):708-710.	
<p>Parment JL, Colonna-Romano P, Horrow JC, Miller F, Gonzales J, Rosenberg H.</p> <p>The laryngeal mask airway reliably provides rescue ventilation in cases of unanticipated difficult tracheal intubation along with difficult mask ventilation.</p> <p><i>Anesthesia and Analgesia</i>. 1998;87(3):661-665.</p>	Non Cesarean Section (CS) patients studied.
<p>Shibli KU, Russell IF. A survey of anaesthetic techniques used for cesarean section in the UK in 1997. <i>Int J Obstet Anesth</i>. 2000;9(3):160-167.</p>	Survey of anesthesiologists, not an interventional study.
<p>Tao W, Edwards JT, Tu F, Xie Y, Sharma SK. Incidence of unanticipated difficult airway in obstetric patients in a teaching institution. <i>Journal of Anesthesia</i>. 2012;26(3):339-345.</p>	No use of an LMA.
<p>Wang J, Shi X, Xu T, Wang G.</p> <p>Predictive risk factors of failed laryngeal mask airway insertion at first attempt.</p> <p><i>The Journal of international medical</i></p>	No outcomes of interest.

research. 2018;46(5):1973-1981.	
Fang X, Yao W, Li S. [Application of Supreme double-chamber laryngeal mask in general anesthesia for cesarean section pregnant women]. <i>Chinese Medical Journal</i> . 2013;93(19):1479-1481.	No outcomes of interest.
Zhao L, Li B, Luo Y, Jia S. The feasibility, safety and observation of the SLIPA laryngeal mask in general anesthesia for Cesarean section. <i>Practical Journal of Clinical Medicine</i> . 2013;10(5):128-130.	No outcomes of interest.
Amin S, Fathy S. Can i-gel Replace Endotracheal Tube during Elective Cesarean Section? <i>J Anesth Clin Res</i> . 2016;07(02).	No endotracheal tube control group.
Barnardo PD, Jenkins JG. Failed tracheal intubation in obstetrics: a 6-year review in a UK region. <i>Anaesthesia</i> . 2000;55(7):690-694.	No endotracheal tube control group.

<p>Fang X, Xiao Q, Xie Q, et al. General Anesthesia with the Use of SUPREME Laryngeal Mask Airway for Emergency Cesarean delivery: A Retrospective Analysis of 1039 Parturients. <i>Sci Rep.</i> 2018;8.</p>	<p>No endotracheal tube control group.</p>
<p>Halaseh BK, Sukkar ZF, Hassan LH, Sia AT, Bushnaq WA, Adarbeh H. The use of ProSeal laryngeal mask airway in caesarean section--experience in 3000 cases. <i>Anaesth Intensive Care.</i> 2010;38(6):1023-1028.</p>	<p>No endotracheal tube control group.</p>
<p>Han TH, Brimacombe J, Lee EJ, Yang HS. The laryngeal mask airway is effective (and probably safe) in selected healthy parturients for elective Cesarean section: a prospective study of 1067 cases. <i>Can J Anaesth.</i> 2001;48(11):1117-1121.</p>	<p>No endotracheal tube control group.</p>
<p>Li SY, Yao WY, Yuan YJ, et al. Supreme laryngeal mask airway use in general Anesthesia for category 2 and 3</p>	<p>No endotracheal tube control group.</p>


<p>Cesarean delivery: a prospective cohort study. <i>BMC Anesthesiol.</i> 2017;17(1):169.</p>	
<p>McDonnell NJ, Paech MJ, Clavisi OM, Scott KL. Difficult and failed intubation in obstetric anaesthesia: an observational study of airway management and complications associated with general anaesthesia for caesarean section. <i>Int J Obstet Anesth.</i> 2008;17(4):292-297.</p>	<p>No endotracheal tube control group.</p>
<p>Cook TM, Woodall N, Frerk C. Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. Part 1: anaesthesia. <i>Br J Anaesth.</i> 2011;106(5):617-631.</p>	<p>No endotracheal tube control group.</p>
<p>Quinn AC, Milne D, Columb M, Gorton H, Knight M. Failed tracheal intubation in obstetric anaesthesia: 2 yr national case-control study in the UK. <i>Br J Anaesth.</i> 2013;110(1):74-80.</p>	<p>No endotracheal tube control group.</p>
<p>Rahman K, Jenkins JG. Failed tracheal</p>	<p>No endotracheal tube control group.</p>

intubation in obstetrics: no more frequent but still managed badly. <i>Anaesthesia</i> . 2005;60(2):168-171.	
Rajagopalan S, Suresh M, Clark SL, Serratos B, Chandrasekhar S. Airway management for cesarean delivery performed under general anesthesia. <i>Int J Obstet Anesth</i> . 2017;29:64-69.	No endotracheal tube control group.
Yao WY, Li SY, Sng BL, Lim Y, Sia AT. The LMA Supreme in 700 parturients undergoing Cesarean delivery: an observational study. <i>Can J Anaesth</i> . 2012;59(7):648-654.	No endotracheal tube control group.
Sng BL, Yao WY, Li SY, Han RN, Sultana R, Sia AT. Comparison of the LMA Supreme with tracheal intubation for airway management during general anesthesia for cesarean delivery: A randomised controlled trial. <i>Abstracts of free papers presented at the annual meeting of the Obstetric Anaesthetists' Association, Brussels, May 18-X 2017</i> . <i>Int J Obstet Anesth</i> . 2017;31:S7-S61.	Duplicate study of Yao et.al. 2019.



**Author(s):**  
**Date:**  
**Question:** SGA compared to ETT for Obstetric Anaesthesia  
**Setting:**  
**Bibliography:** . SGA versus ETT for Obstetric Anaesthesia. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Certainty assessment							N <sub>o</sub> of patients		Effect		Certainty	Importance
N <sub>o</sub> of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SGA	ETT	Relative (95% CI)	Absolute (95% CI)		
First Attempt Success												
5	randomised trials	serious <sup>a,b</sup>	not serious	not serious	serious <sup>c</sup>	publication bias strongly suspected <sup>c</sup>	656/664 (98.8%)	648/664 (97.6%)	OR 1.83 (0.63 to 5.27)	11 more per 1,000 (from 14 fewer to 19 more)	⊕○○○ VERY LOW	CRITICAL
Insertion Time (sec)												
7	randomised trials	serious <sup>a</sup>	very serious <sup>d</sup>	serious <sup>c</sup>	serious <sup>a,d</sup>	none	734	734	-	MD 15.8 lower (25.3 lower to 6.31 lower)	⊕○○○ VERY LOW	CRITICAL
Difficult Placement												
6	randomised trials	serious <sup>a</sup>	not serious	not serious	serious <sup>c</sup>	publication bias strongly suspected <sup>c</sup>	6/659 (0.9%)	0.0%	OR 0.32 (0.07 to 1.41)	0 fewer per 1,000 (from 0 fewer to 0 fewer)	⊕○○○ VERY LOW	CRITICAL
Peak Airway Pressure Pre-delivery												
7	randomised trials	serious <sup>c,d</sup>	very serious <sup>d</sup>	not serious	not serious	publication bias strongly suspected <sup>e</sup>	790	790	-	MD 0.29 higher (0.81 lower to 1.39 higher)	⊕○○○ VERY LOW	IMPORTANT
Laryngeal Spasm												
4	randomised trials	serious <sup>b,c</sup>	not serious	serious <sup>e</sup>	not serious	none	2/169 (1.2%)	6/279 (2.2%)	OR 0.64 (0.10 to 4.09)	8 fewer per 1,000 (from 19 fewer to 61 more)	⊕⊕○○ LOW	IMPORTANT
Blood on Device												
6	randomised trials	serious <sup>a</sup>	not serious	not serious	not serious	none	39/704 (5.5%)	53/704 (7.5%)	OR 0.73 (0.48 to 1.13)	19 fewer per 1,000 (from 38 fewer to 9 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Sore Throat												

11	randomised trials	not serious	serious <sup>d</sup>	not serious	not serious	none	29/954 (3.0%)	129/954 (13.5%)	<b>OR 0.16</b> (0.08 to 0.32)	<b>111 fewer per 1,000</b> (from 123 fewer to 88 fewer)	 MODERATE	IMPORTANT
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**CI:** Confidence interval; **OR:** Odds ratio; **MD:** Mean difference

**Explanations**

- a. Number of studies investigating this outcome is low and there is less than 50% low risk studies in terms of allocation and blinding.
- b. There is significant heterogeneity that can be resolved in one or more of the subgroups.
- c. Number of studies investigating this outcome is low.
- d. There is significant heterogeneity that can not be resolved in any of the subgroups.
- e. Low number of studies investigating this outcome with half being observational studies