volving assisted ventilation through the LMA and moving the patient during light anaesthesia could critically raise intra-gastric pressure.⁸

The question that needs to be asked is whether this incident was due to the presence of the LMA or would it have occurred with a patient receiving a facemask anaesthetic? We feel that until the possible role of the LMA in provoking regurgitation has been fully explored one should follow the advice of Campbell⁷ and consider the LMA an alternative to the facemask, not the endotracheal tube, if its reputation is not to be unjustly tarnished.

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REPLY

We agree with Dr. Asai's comments on gastric emptying in the injured patient, and that the laryngeal mask airway (LMA) was probably an inappropriate choice in this case. However, the problem was not passive regurgitation but active vomiting during too-light anaesthesia. When the vomiting reflex is initiated, whether the stomach is empty or not, intestinal contents may be pushed back into the duodenum and stomach by antiperistaltic waves that begin as far down the intestinal tract as the ileum.¹ Therefore, even if a patient has an "empty"

stomach but shows premonitory signs of vomiting during anaesthesia or emergence, we would still recommend immediate removal of the laryngeal mask to allow the vomitus to flow freely from the mouth.

We also appreciate the comments of Drs. Shorney and Brimacombe. At no point was any attempt made or implied to blame the LMA whose reputation we agree should not be unjustly tarnished. We do not know whether the LMA is more or less likely than an oropharyngeal airway to provoke vomiting; our impression is that, at least during emergence, the LMA is better tolerated. Tone of the lower oesophageal sphincter would have been of minor importance in this case because vomiting causes a dramatic rise in intragastric pressure with reflex relaxation of the lower oesophageal sphincter;¹ resting sphincter tone at that point becomes irrelevant. The main purpose of our report was to point out that, if anaesthesia becomes too light and active vomiting occurs with the LMA in place, severe aspiration pneumonia can occur even if the patient is in the lateral position.

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Complete upper airway obstruction

To the Editor:

We report a case of complete occlusion of the distal limb of a silicone tracheal T tube resulting in a near fatal asphyxial crisis. A 68-year-old man with an annular constriction of his trachea due to adenoid cystic carcinoma was initially treated palliatively with radiotherapy and laser therapy. Increasing dyspnoea, inspiratory stridor and accelerated tumour growth necessitated diathermy and tracheal stenting. Problems with proximal stent migration resulted in a subsequent tracheostomy and insertion of a silicone tracheal T tube, the proximal end being positioned 1.5 cm below the vocal cords. The patient was able to breathe easily but frequent tube changes were necessary due to tumour regrowth and encrusted secretions partially occluding the tube lumen.

Seventy-two hours after a change of T tube the patient was found to be unconscious, deeply cyanosed and making laboured ventilatory efforts. His ECG rhythm showed ventricular tachycardia. The history was not immediately available and attempts both to oxygenate him conventionally through a face mask and to insufflate oxygen through his T tube were unsuccessful. The diagnosis of a blocked tube was made but in view of the primary