

sidered to be at high risk of regurgitation and aspiration. However, whilst the OTC probably offers increased airway protection, its value has not been proved in this clinical situation. The LMA does not protect the trachea from regurgitated stomach contents, but has been shown, by Baraka amongst others,⁴ to be life-saving on occasions where tracheal intubation and FM ventilation have both failed. The risk/benefit ratios of these two devices have not been assessed and it is premature to presume that one is superior to the other. The LMA is commonly used during general anaesthesia making it more familiar and immediately available; it can be used in children and it can also be used as an airway intubator.⁵ There is also indirect evidence that LMA insertion is not compromised in the patient with a difficult airway.⁶⁻⁹ In a recent trial, the LMA was used 41 times in 40 adult patients sustaining a cardiopulmonary arrest at a district general hospital. The LMA failed on only two occasions, and was successful in three cases where tracheal intubation was impossible. There were no cases of LMA-related aspiration.¹⁰

J. Brimacombe MB ChB FRCA

A. Berry MB ChB FRCA

Department of Anaesthesia and Intensive Care
Cairns Base Hospital
The Esplanade
Cairns 4870
Australia

REFERENCES

- 1 Baraka A, Salem R. The combitube oesophageal-tracheal double lumen airway for difficult intubation (Letter). *Can J Anaesth* 1993; 40: 1222-3.
- 2 Practice Guidelines for Management of the Difficult Airway - a Report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway. *Anesthesiology* 1993; 78: 597-602.
- 3 Benumof JL. Management of the difficult adult airway - with special emphasis on awake tracheal intubation. *Anesthesiology* 1991; 75: 1087-110.
- 4 Baraka A. Laryngeal mask airway in the cannot-intubate, cannot ventilate situation. *Anesthesiology* 1993; 79: 1151.
- 5 Maltby JR, Loken RG, Watson NC. The laryngeal mask airway: clinical appraisal in 250 patients. *Can J Anaesth* 1990; 37: 509-13.
- 6 Mahiou P, Narchi P, Veyrac P, Germond M, Gory G, Bazin G. Is laryngeal mask easy to use in case of difficult intubation? *Anesthesiology* 1992; 77: A1228.
- 7 Brimacombe J, Berry A. Mallampatti classification and laryngeal mask insertion. *Anaesthesia* 1993; 48: 347.
- 8 Pennant JH, Gajraj NM, Pace NA, Hastings RH.

Laryngeal mask airway in cervical spine injuries. *Anesth Analg* 1992; 75: 1074-5.

- 9 Brimacombe J, Berry A. Laryngeal mask airway insertion. A comparison of the standard versus neutral position in normal patients with a view to its use in cervical spine instability. *Anaesthesia* 1993; 48: 670-671.
- 10 Leach A, Alexander CA, Stone B. The laryngeal mask in cardiopulmonary resuscitation in a district general hospital: a preliminary communication. *Resuscitation* 1993; 25: 245-8.

REPLY

The "cannot intubate, cannot ventilate" situation denotes a situation when both tracheal intubation and face mask ventilation have failed. Our patient fell into this category, and hence the Oesophageal Tracheal Combitube (OTC) was utilized for ventilation.¹ The Laryngeal Mask Airway (LMA) has been also life-saving in similar occasions.²

Although the OTC probably offers airway protection in the "full-stomach" situation, the LMA may decrease lower oesophageal sphincter pressure,³ and does not protect the trachea from regurgitated stomach contents. However, I agree with Brimacombe and Berry that the risk/benefit ratios of these two devices have not been assessed in patients with "full-stomach," and it is premature to presume that one is superior to the other.

Anis Baraka MD FRCA (Hon)
Department of Anesthesiology
American University of Beirut
Beirut - Lebanon

REFERENCES

- 1 Baraka A, Salem R. The combitube oesophageal-tracheal double lumen airway for difficult intubation (Letter). *Can J Anaesth* 1993; 40: 1222-3.
- 2 Baraka A. Laryngeal mask airway in the cannot intubate, cannot ventilate situation. *Anesthesiology* 1993; 79: 1151.
- 3 Rabey PG, Murphy PJ, Langton JA, Barker P, Rowbotham DJ. Effect of the laryngeal mask airway on lower oesophageal sphincter pressure in patients during general anaesthesia. *Br J Anaesth* 1992; 69: 346-8.

Succinylcholine warning

To the Editor:

We read with complete disbelief of the recommendation from Burroughs Wellcome against the use of succinylcholine in adolescents and children. Like our colleagues in Toronto, we have used this drug in the majority of anaesthetics administered to children since the 1950's and found it to be extremely useful, reliable and safe.

The discovery of an adverse effect of a drug should not prompt an immediate recommendation not to use it. All drugs have adverse effects, the only way to avoid them completely is to not use drugs at all. The decision should only be based on the risk/benefit ratio of the drug

in question against the risk/benefit ratio of the available alternatives, and cannot be made by the pharmaceutical industry considering their product in isolation.

We would like to endorse the opinion of the anaesthetic department of The Hospital for Sick Children, Toronto¹ that succinylcholine should continue its important role in the airway management of infants, children and adolescents.

R. Bingham
E. Battersby
A. Black
E. Facer
D. Hatch
R. Howard
I. James
A. Lloyd-Thomas
A. Mackersie
E. Sumner
M. Sury
Department of Anaesthesia
The Hospital for Sick Children
Great Ormond Street
London
England

REFERENCE

- 1 Lerman J, Berdock SE, Bissonnette B, et al. Succinylcholine warning. *Can J Anaesth* 1994; 41: 165.

Anaesthesia – “tricks of the trade”

To the Editor:

When I was a resident I was impressed that many of my staff had these little “tricks” of intubation that they used on the difficult cases. Unfortunately, these little pearls never make it into the publications. They were not submitted for publication because they were felt to be “too minor,” “too obvious” (i.e., “everyone knows that”), “unproven,” “bizarre” (i.e., “too far off the beaten track”), “not publishable,” “works for me, may not work for others,” “heard about it, never tried it” or “only tried it once” or any number of reasons.

It may be that not “everyone” knows “that.” It may be “unproven” or “bizarre sounding,” but it may nevertheless be a life saver at some time. I would like to gather and present these word of mouth “tricks of the trade” to a wider audience – with the suitable caveats of course. I am looking specifically for those gems that are passed on by word of mouth and never make it into

the standard textbooks or promoted in review articles. This may be some special manoeuvre, non-standard use of available instruments or improvised use of some other piece of equipment. A brief note as to the source for the manoeuvre and how it was used would be helpful.

If any publication results, I will cite the sources of all unique “tricks of the trade,” so please identify these on the sheet. Even if no publication results, I will make a copy of the survey available on request, to all contributors.

I would like to ask the readers of the Journal to be so kind as to take a few moments and jot them down on this sheet and either fax 416-586-8664 or send them to me.

J.A. Fisher MD FRCPC
Mount Sinai Hospital
600 University Avenue
Toronto, Ontario M5G 1X5
Canada

Erratum

Uchida T, Makita K, Tsunoda Y, Toyooka H, Amaha K. Clinical assessment of a continuous intra-arterial blood gas monitoring system. *Can J Anaesth* 1994; 41: 64–70.

Please note that some of the results in Table II on page 66 were transposed. The corrected numbers are underlined.

TABLE I Correlation analysis and accuracy

	OR	ICU
<i>pH</i>		
Pearson's r value	0.77	0.79
Bias (pH unit)	<u>0.005</u>	<u>0.003</u>
Precision (pH unit)	<u>0.035</u>	<u>0.030</u>
<i>PCO₂</i>		
Pearson's r value	0.77	0.8
Bias (mmHg)	-2.8	<u>2.1</u>
Precision (mmHg)	<u>3.9</u>	3.8
<i>PO₂</i>		
Pearson's r value	0.95	0.98
Bias (mmHg)	0.9	8.5
Precision (mmHg)	29.9	14.7
<i>PO₂ < 200 mmHg</i>		
Bias (mmHg)	0.6	7.0
Precision (mmHg)	18.1	12.0