respiratory distress with audible inspiratory stridor accompanied by cyanosis, chest retractions, and decrease in oxygen saturation (SPO₂). Positive-pressure oxygen was immediately applied by face mask, and preparation for tracheal intubation commenced. Auscultation of the lungs revealed clear breath sounds bilaterally, suggesting laryngospasm. The spasm broke after about 50 sec and SPO₂ returned to normal. Following a second identical episode some minutes later, the woman exclaimed that she has had these "asthmatic" attacks whenever she is excited such as on her wedding day and during her brother's funeral. Direct laryngoscopy under topical anaesthesia by an otolaryngologist revealed normal structures, confirming the psychogenic origin of the attacks. There were no further complications.

Psychogenic inspiratory laryngospasm, which affects primarily emotional young women, is considered to be a conversion neurosis.¹ The diagnosis is suggested by history, noisy inspiratory stridor and hoarseness and can be verified only during an attack.^{1,2} This explains the frequent misdiagnosis of asthma,³ as in our patient. The spasm frequently develops during a period of hyperventilation.² Treatment consists of psychotherapy, speech therapy, and teaching of respiratory techniques.³

Inquiry into the specifics of our patient's "asthmatic" attacks may have led to the use of preventive measures at the stressful time of parturition, such as mild sedation and verbal reassurance.

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Intraoperative monitoring in patients with Moyamoya disease

To the Editor:

Both general and regional anaesthesia are suitable for surgery in patients with Moyamoya disease, as long as the cerebral perfusion is well maintained.^{1,2} Arterial or end-tidal CO₂ monitoring has been recommended to ensure normocarbida or slight hypercarbida.³⁻⁵ We propose that jugular bulb catheterization for venous oxygen saturation (SjO₂) is a useful monitor in these patients.

Cerebral oxygen extraction ratio (O₂ER) reflects the portion of the oxygen delivered to the brain that is consumed. O₂ER may be calculated from the arterial (SaO₂) and jugular bulb venous oxygen saturation (SjO₂):

$$O_2ER = \frac{SaO_2 - SjO_2}{SaO_2} \times 100$$

An increase in O₂ER may be due to increased cerebral oxygen consumption or decreased cerebral oxygen delivery. When cerebral oxygen consumption is stable, O₂ER is a useful index of oxygen delivery. O₂ER below 40% is interpreted as adequate cerebral perfusion.

We managed a 45-yr-old woman with Moyamoya disease for cerebral revascularization by encephalo-duro-arterio-synangiosis (EDAS). She had suffered two disabling left hemispheric strokes within 12 months. An uneventful left EDAS was performed under isoflurane anaesthesia, with end-tidal CO₂ maintained between 35 and 40 mmHg. When she returned to right EDAS, the O₂ER during the perioperative period ranged from 25.5% to 39.8% (Table). The perioperative course was uneventful, and the patient suffered no new neurological deficits.

TABLE

Time	Vent	PETCO ₂ (mmHg)	PaCO ₂ (mmHg)	SpO ₂ (%)	PaO ₂ (mmHg)	SaO ₂ (%)	PjO ₂ (mmHg)	SjO ₂ (%)	O ₂ ER
0910	OR: CV	34	37	97	216	98	33	59	39.8%
1000	OR: CV	41	42	98	222	98	43	73	25.5%
1045	OR: CV	40	44	98	203	98	37	62	36.7%
1200	PAR: SV	-	53	100	197	98	43	72	26.5%
1230	PAR: SV	-	49	100	206	98	37	65	33.7%

Time = real time; Vent = ventilation time; OR:CV = operating room: controlled ventilation; PAR = post-anaesthetic recovery: spontaneous ventilation.

Jugular bulb catheterization provides an added dimension for ensuring adequate cerebral perfusion and oxygenation.

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LMA insertion after accidental extubation

To the Editor:

Sudden, accidental tracheal extubation during surgery is hazardous, especially when the tracheal patient is in a position which inhibits reintubation (e.g., ventral position). We have had a case of unexpected extubation and managed it by immediate insertion of an LMA. An endotracheal tube was inserted in a 70-yr-old woman who was anaesthetised using balanced anaesthesia with muscle relaxants. Ventilation was controlled and the patient was placed in the left lumbar position with maximal extension of her pelvis, to obtain a good exposure of the kidney. When the operating table was flexed for closure of the incision, the tubing of the respirator was stretched and the trachea was unintentionally extubated. A # 3 LMA was inserted and the cuff inflated with 40 ml air, without changing the lumbar position of the patient. There were no haemodynamic changes, the O₂ saturation remained at 99%, peak airway pressure of 28 mmHg and PETCO₂ at 32 mmHg. These variables were maintained until the completion of the operation. The capnograph screen depicted a normal respiratory curve without any change after the insertion of the laryngeal mask.

Manual, controlled ventilation was continued with a

bag connected to the circle system for 12 min, with the patient in a lateral position. This allowed for a safe closure of the surgical incision. Afterwards, the patient was placed on her back. Reversal of the neuromuscular block was achieved by neostigmine and atropine with resumption of spontaneous respiration.

We believe that the use of a laryngeal mask is the preferred approach in this situation.¹ As many operations are performed in unconventional positions, laryngeal mask anaesthesia may be useful to resolve the problem of sudden loss of airway during surgery,² and we recommend it be available in all operating room suites.

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Erratum

McLeod DH, Wong DHW, Vaghadia H, Claridge RJ, Merrick PM. Lateral popliteal sciatic nerve block compared with ankle block for analgesia following foot surgery. *Can J Anaesth* 1995; 42: 765–9.

Please note that on the last line on page 767 the “t” was omitted from “t tests”. The line should read:

group differences with unpaired t tests. Weight, anaesthetic