suggestion regarding grouping intubating techniques, the choice of the word "blinded" or "non-visual" is a matter of personal preference.

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No time to change

To the Editor:

We wish to describe a case where the practice of changing volatile agent after inhalation induction of anesthesia to reduce cost may have resulted in serious morbidity.

A three-year-old child was anesthetized with sevoflurane 8% in oxygen. Once asleep, the concentration of sevoflurane was reduced to 4% and nitrous oxide 60% added and intravenous access established. A laryngeal mask (LMA) was inserted with ease and isoflurane 1.5%, a less expensive anesthetic agent, was substituted for sevoflurane. The child was then positioned in the left lateral position for a caudal block. On cleaning the skin the child moved and regurgitated gastric contents resulting in laryngospasm. The arterial hemoglobin oxygen saturation (SpO_2) decreased to 83%. The LMA was immediately removed and the oropharynx cleared. Continuous positive airway pressure was applied by facemask and 1 mg·kg⁻¹ succinylcholine administered. The child was turned supine, trachea intubated and lungs ventilated, the SpO_2 returning to 99%. The caudal was successfully completed and surgery continued with no further incident.

Patients should at an adequate depth of anesthesia when using the LMA to avoid regurgitation and possible aspiration of gastric contents.¹ Switching volatile agents resulted in an inadequate depth of anesthesia as recovery from sevoflurane was faster than induction with isoflurane (blood/gas partition coefficients 0.6 and 1.4 respectively). The practice of changing volatile agents for cost savings during anesthesia should be discouraged in favour of low flow anesthesia especially when the airway is unprotected such as when using a facemask or LMA.

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The proportion of high risk preterm infants with postoperative apnea and bradycardia is the same after general and spinal anesthesia

To the Editor:

In contrast to general anesthesia, spinal anesthesia for herniorrhaphy may protect preterm infants from postoperative apnea.¹⁻⁴ In a prospective controlled study we investigated whether unsupplemented spinal anesthesia (uSA) reduces the proportion of premature infants with postoperative cardiorespiratory events compared with general anesthesia (GA).

After ethical approval patients were randomly assigned to receive uSA (11 mg·kg⁻¹ isobaric bupivacaine) 0.5% or GA (N₂O/halothane). The occurrence of events was continuously registered 12 hr pre- and 48 hr postoperatively. "Worrying" apnea - apnea > 15 sec or apnea of 10-15 sec with bradycardia (HR < 100 bpm) and - "unworrying" apnea as apnea without bradycardia lasting 10-15 sec.

Patients presented with a very low gestational age at birth (uSA: 26.9 ± 2.0 wk, n = 8; GA: 29.7 ± 3.7 wk, n = 9;) and a history of apnea and bradycardia. After the investigation of 17 patients, a similar proportion of infants with worrying apnea was observed in the uSA-group (50%) and in the GA-group (44%) (Table). The first event of worrying apnea occurred between 1 and 16 hr postoperatively. However, there were more unworrying apneas per patient in the GA-group than in the uSA-group during the first 12 hr postoperatively ($P < 0.017$).

We conclude: 1) High risk preterm infants are not protected from worrying postoperative cardiorespiratory events after uSA. 2) The postoperative respiratory pattern after GA is altered over 12 hr in contrast to uSA. 3) Irrespective of the type of anesthesia, monitoring of high risk preterm infants is indicated for at least 16 hr postoperatively.

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