Correspondence

Consent in anesthesia research: the pre-admission phone call

To the Editor:

Authors of clinical research papers must state that patients gave informed consent, but not when, where, how or by whom consent was obtained. In the 1980s, the University of Calgary Research Ethics Board (REB) refused to approve anesthesia studies unless patients were approached before hospital admission. This was upheld by the National Council of Bioethics in Human Research,¹ but anesthesiologists in Calgary believed this would breach confidentiality because investigators and research assistants are "strangers"² to patients before admission.

Since 1993, the Calgary REB has considered staff anesthesiologists, residents, and research assistants as a single unit, whereas in Seattle the research assistant takes the role of OR booking clerk. This permits a pre-admission telephone call outlining the protocol to patients, who can decline at once or receive full details on admission. Those who are interested look forward to meeting the research assistant to review the protocol. They then have time to read the consent form in privacy, ask questions, and make a final decision. Their positive attitude is comparable to the Hawthorne effect, in which workers' attitudes and performance improved when their help and advice were sought by the company.³

Our concern that patients might resent being approached over the telephone by a "stranger" were unfounded. An informal survey of 84 American and Canadian centres revealed that only 16 use the pre-admission telephone call.* We have now used this process in several hundred patients and can commend it to other investigators and REBs.

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Calgary, Alberta

References

- 1 Questions and advice: research ethics. National Council on Bioethics in Human Research Communiqué 1993; 4: April/May: 2-3.

2 Maltby JR, Eagle CJ. Informed consent for clinical anesthesia research. Can J Anaesth 1993; 40: 891-6.

3 The New England Britannica, 15th ed. 1998; Chicago 29: 925.

* Details of telephone survey available from the authors

Use of the laryngeal mask after tracheal extubation

To the Editor:

Dob and colleagues recently studied respiratory complications associated with the use of the laryngeal mask or Guedel airway after tracheal extubation and found that complications were much fewer for the laryngeal mask than for the Guedel airway.¹ However, this point had already been shown² well before the acceptance date of Dob and colleagues' article. They omitted to cite this previous randomized study, which compared the incidence of respiratory complications under the following three circumstances: tracheal extubation while the patient was still deeply anesthetized followed by the use of either the laryngeal mask or Guedel airway during emergence from anesthesia, and tracheal extubation after the patient had regained consciousness.²

Several authors, including Dob's colleagues, have suggested extubating the trachea while the patient is still anesthetized and then inserting the laryngeal mask.³⁻⁵ However, there is a risk of losing a patent airway if insertion of the laryngeal mask is impossible after tracheal extubation. I reported a simple method which can avoid this risk - insertion of the laryngeal mask *before* tracheal extubation (with an explanatory photograph).^{2,6} Dob and colleagues omitted to mention my idea despite their use of the latter method (and a very similar photograph to mine) in their study.

Takashi Asai MD PhD
Osaka, Japan

References

- 1 Dob DP, Shannon CN, Bailey PM. Efficacy and safety of the laryngeal mask airway vs Guedel airway following tracheal extubation. Can J Anesth 1999; 46: 179-81.
- 2 Koga K, Asai T, Vaughan RS, Latta IP. Respiratory complications associated with tracheal extubation. Timing of tracheal extubation and the use of the laryn-

geal mask during emergence from anaesthesia. *Anaesthesia* 1998; 53: 540-4.

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- 4 Glaisyer HR, Pany M, Lee J, Bailey PM. The laryngeal mask airway as an adjunct to extubation on the intensive care unit (Letter). *Anaesthesia* 1996; 51: 1187-8.
- 5 Costa e Silva L, Brimacombe JR. Tracheal tube/laryngeal mask exchange for emergence (Letter). *Anesthesiology* 1996; 85: 218.
- 6 Asai T. Use of the laryngeal mask during emergence from anaesthesia (Letter). *Eur J Anaesthesiol* 1998; 15: 379-82.

REPLY:

We thank Dr Asai for his interest in our paper.¹ We would like to make the following points.

First, we submitted our paper to the *Canadian Journal of Anesthesia* in March 1998 before Dr Asai's paper² was published in June 1998. He was, therefore not cited in our work. Second, Dr Asai's "novel" idea of placing a laryngeal mask airway before tracheal extubation has been in common use at our institution, the Royal National Throat Nose and Ear Hospital since 1994.

Furthermore, it is interesting that Dr Asai notes the similarities between the photographs in both articles. Our photographs were presented by the senior author (PMB) at Dr Asai's institution, University Hospital Cardiff, in December 1995.

Daryl P. Dob FRCA
Paul M. Bailey FRCA
London, United Kingdom

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- 1 Dob DP, Shannon CN, Bailey PM. Efficacy and safety of the laryngeal mask airway vs Guedel airway following tracheal extubation. *Can J Anesth* 1999; 46: 179-81.
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Misleading end-tidal CO₂ tensions

To the Editor:

I have recently read the article by Drs. Wahba and Tessler¹ and there is an important error in Figure 1. The triangle representing the gradient of ventilation is inverted: they indicate that ventilation is higher at the

apex and lower at the base but the reverse is the correct situation.

Both ventilation and perfusion are higher at the base and lower at the apex but the $\dot{V}/\dot{Q}$ ratio is higher at the apex because the perfusion gradient is steeper than the ventilation gradient.

Kerry Brandis FANZCA
Queensland, Australia

Reference

- 1 Wahba RW, Tessler MJ. Misleading end-tidal CO₂ tensions. *Can J Anaesth* 1996; 43: 862-6.

REPLY:

It is, of course, gratifying for us that our article is still being read three years after publication.

The arrow indicating the directional change in $\dot{V}/\dot{Q}$ shows that the latter increased up the lung. The triangles were meant to depict alveolar size and perfusion head at rest i.e. FRC. Apical units are largest at FRC and expand comparatively little with breathing. Their contribution to expired CO₂ thus is also smaller. That was the intended message.

Richard Wahba MD FRCPC
Michael Tessler MD FRCPC
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Every endotracheal tube needs a Murphy eye!

To the Editor:

The Murphy eye is a hole at the tip of the endotracheal tube to prevent tube obstruction if the beveled end of the tube is obstructed by mucus or sealed by contact with the tracheal wall.¹ All endotracheal tubes have the Murphy eye except for some spiral tubes. We encountered complete tube obstruction when we used a J-shaped endotracheal spiral tube (JSETST) without a Murphy eye.

A 60-yr-old man underwent radical neck resection. We inserted a JSETST (ø-con, Fuji systems, Tokyo, Japan) into the trachea via the tracheostomy. Two hours later, we suddenly could not ventilate the lungs because the beveled end of the tube was obstructed by the dorsal tracheal wall as the surgeon accidentally pulled the tube by the elbow (Figure 1).

Because the JSETST has a coil in its soft silicone wall, part of the tube stands in the tracheal cavity. The JSETST's beveled end is cut at a right or narrow