

SpO₂ was greater than 97%; 3) a tube exchanger catheter was inserted through the ET; 4) the LMA® and ET were withdrawn together; 5) an ET size ID 8 mm was threaded over the tube exchanger.

With an unhurried approach we achieved safe control of the airway, with adequate oxygenation and mechanical ventilation in a few minutes.

Use of the LMA plus a modified sequential technique proved to be an appropriate strategy to achieve airway control in this patient with an unanticipated difficult airway in an environment where all ancillary equipment and personnel for managing this unexpected complication may not be available.

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Sevoflurane induction of anesthesia in elderly patients

To the Editor:

We read with interest the paper by Yamaguchi *et al.*¹ concerning the establishment of an appropriate technique for high concentration induction of anesthesia with sevoflurane in the elderly. We have four comments.

The first one concerns the absence of preoxygenation. Although the benefit of preoxygenation remains to be demonstrated if a mixture of 100% O₂ and sevoflurane is used for vital capacity induction like in the present study, we would suggest that the importance of preoxygenation at least before *iv* induction is widely accepted.²

The second comment concerns waste anesthetic gases during vital capacity induction. It is desirable to minimize exposure to trace anesthetic gases. The use

of the SiBI™ connector (Ventitech Medical Devices, Sherbrooke, Quebec, Canada) designed for vital capacity induction could be useful for both preoxygenation and reduction of waste anesthetic gases.³

Thirdly, opioids are useful to avoid cardiovascular responses to endotracheal intubation. Figures 1 and 2 do indicate a hemodynamic response to intubation in the three groups. Small doses of opioids could be useful to prevent such changes, but should be limited because of the possibility of bradycardia with higher doses of opioids and sevoflurane at vital capacity induction.⁴

Finally, we feel that time to loss of consciousness and time to disappearance of eyelash reflex are longer than generally observed in Groups II and III. We suggest that monitoring of those two times should be a continuous process, not an intermittent process at ten-second intervals.

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REPLY

We thank Colas *et al.*¹ for their comments on our induction technique,² whereby high concentrations of sevoflurane are inhaled initially and concentration is reduced gradually thereafter. We would like to respond and discuss their suggestions. First, they suggest that preoxygenation should be used before anesthesia induction. In our technique, preoxygenation was not used in order to simplify the technique for inhalation induction in the elder-