unnoticed because the LMA is used mostly for short cases with spontaneously breathing patients.

As implemented with the LT, the measurement, management, and monitoring of intracuff pressure have to become routine practice with any extraglottic airway device.

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REPLY:

We thank Drs. Matic and Arndt for their interest in our paper. We agree that intracuff pressure limitation is seldom performed, but should be a standard of practice with any cuffed extraglottic airway device to reduce mucosal pressure. The target intracuff pressure should be the minimum required to form an effective seal with the respiratory tract (all devices) and gastrointestinal tract (those devices with distal cuffs in the hypopharynx or esophagus). Determining the seal with the respiratory tract is easy since intracuff pressure can be titrated against ventilation; however, determining the seal with the gastrointestinal tract is difficult since air usually leaks out the mouth rather than into the esophagus.¹ We suggest that cuff volume is adjusted so that there is a slight oropharyngeal leak at the required ventilatory setting and then adding air until this leak just disappears. This intracuff pressure should be the target pressure for subsequent adjustments. It is important to appreciate that for most extraglottic devices, including the laryngeal tube airway, intracuff pressure is much higher than mucosal pressure due to the elastic properties of the cuff.²

An easy way to determine mucosal pressure is to subtract in vivo from in vitro intracuff pressure for a given cuff volume. Finally, another clinical test that is seldom performed, but should be a standard of practice, and which is perhaps more important than intracuff pressure limitation, is epigastric auscultation. Epigastric auscultation can detect gastric insufflation of 4 mL air after one breath with 95% confidence.³

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An unusual cause of difficulty confirming correct placement of an endotracheal tube

To the Editor:

An otherwise healthy 46-yr-old man underwent circumferential cervical spine decompression and instrumented fusion. Due to the patient's neurologic symptoms, the surgeon requested that the intubation be done awake. After topicalization of the airway and insertion of the endotracheal tube, a regular end-tidal carbon dioxide waveform and misting of the tube were both observed to be present. In addition, the patient could no longer speak. After *iv* induction, the patient's breathing was assisted with manual ventilation, and the chest was seen to rise with each breath. When auscultation of the chest was performed to confirm that breath sounds were equal and bilateral, no breath sounds were heard. The end of the stethoscope was examined, and the diaphragm was tapped with a fingertip, which was easily heard. Repeat auscultation of the chest resulted in no breath sounds being detected. The end of the stethoscope was rotated, and the bell was tapped with a fingertip, which again was easily heard. When the chest was auscultated with the bell, still no breath sounds were detected. At this