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Reply:

“Any Harbour in a Storm”

We are honoured by the interest in our letter¹ by Drs. Wong and McGuire. Of the laryngeal mask airway (LMA) limitations identified by Osborn,² Turkstra,¹ and Wong and McGuire, the circuit connector is the most hindering.

Our purpose had been to inform anesthesiologists of a novel airway technique; Wong and McGuire suggest two other potential techniques that could be considered if a supraglottic device is present and intubation becomes necessary. The *Intubating Laryngeal Airway*TM (LMA North America, San Diego, CA, USA) could have advantages over the LMA-UniqueTM, as professed by Wong and McGuire. However, the ILATM has only recently been approved and hospital availability is limited compared to LMATM products. The ILATM was not approved for use when the events described in our letter took place. Hopefully the advantages proposed by Wong and McGuire will lead to wider acceptance and accessibility of the ILATM devices. Note that the ILATM has recently been approved in a disposable form, the *air-Q*TM.

We concur that the Aintree intubation catheter (Cook Inc, Stouffville, ON, Canada) is an excellent option for intubating patients who have a supra-glottic airway in place, as previously described by several authors.^{3,4} The Aintree device is easier to advance through the LMA than an ETT, and the potential to oxygenate the patient with the Aintree catheter should not be overlooked.

We did not describe a “cannot intubate-cannot ventilate” (CICV) situation, but a contaminated supraglottic airway with difficult fibre-optic laryngoscopy and restricted access (easy ventilation). That being said, we would add that, if ventilation through a supraglottic airway is inadequate, leading to CICV, one should also consider fibre-optic guided intubation,⁵ free-hand or through the supra-glottic airway. If possible, it may be quicker than a surgical option.

“Any harbour in a storm” is sage advice; hopefully our technique and those advanced by Wong and McGuire can provide haven to a colleague in need.

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The Esophageal-Tracheal Combitube® and esophageal injuries

To the Editor:

We read with interest the article of Vezina *et al.* “Complications associated with the Esophageal-Tracheal Combitube® in the pre-hospital setting.”¹ It would be of interest to know which Combitube sizes were used for the patients who experienced complications. The authors collected data regarding Combitube size, but did not report the findings.

The Combitube is available in two sizes: small adult (SA) Combitube (37 Fr), recommended for patients with a height between 120 to 180 cm, and the large adult Combitube (41 Fr) for patients taller than 180 cm, with an overlap between both sizes.² The external diameter of the Combitube 41 Fr is relatively large, and may constitute a potential risk for damage to soft tissue. It has been recommended that the SA Combitube (37 Fr) be used independent of an upper height limit.^{3,4} Due to its smaller size, the SA Combitube (37 Fr) is easier to use, and may be less traumatic to soft tissues.