

the LMA. A study on cadavers suggested that the LMA did not interfere with CP once *in situ*.<sup>1</sup> There has been some uncertainty about the effect of CP on LMA insertion,<sup>2,3</sup> but early results from a randomised, blinded study during conditions mimicking failed intubation indicate that insertion is successful in 90% of patients with CP applied.

Defining the position of the LMA in a failed intubation drill (FID) still requires discussion and we would like to suggest the following guidelines: the use of the LMA in failed intubation will usually follow unsuccessful use of the FM with CP applied. We would suggest that LMA insertion should be attempted initially with maintained CP and, if this fails, then a second attempt should be made with transient release of CP. If an adequate airway is still not achieved, then the FM should be reapplied without CP before resorting to a cricothyrotomy.

We feel that there may be a situation where the LMA could be a first-line alternative in a FID. If difficulty with the FM was anticipated, and considering that the optimal time for LMA insertion is before the patient's reflexes return, then it may be safer to opt for the LMA before the FM. However, the anaesthetist would need to be skilled at using the LMA and conditions must be suitable for LMA insertion. Finally, we would suggest that it would be safer to continue with the LMA or wake the patient rather than attempting blind intubation via the LMA since successful placement is uncertain.

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- 2 *Brimacombe J*. Cricoid pressure and the laryngeal mask airway. *Anaesthesia* 1991; 46: 986–7.
- 3 *Ansermino JM, Blogg CE*. Failed trachea intubation at caesarean section and the laryngeal mask. *B J Anaesth* 1992; 69: 465–7.

#### REPLY

*Thank you for the opportunity to answer to the letters of Drs. Levy, Asai and Appadurai, and Brimacombe and Berry. It is known that by the 34th week of pregnancy gastric emptying time can be prolonged by up to 60%.<sup>1</sup> In the case we presented<sup>2</sup> the patient was fasting for more than 12 hours, and received a non-particulate antacid as part of the preoperative routine. The risk of gastric content aspiration was considered minor*

*in our case. The findings of Rabey et al.<sup>3</sup> are extremely interesting. Unfortunately, at the time we submitted our paper they were not yet printed. As Drs. Asai and Appadurai pointed out the studies to date on the effect of the laryngeal mask airway (LMA) on the incidence of the regurgitation show conflicting results and are very few. In our opinion this issue awaits further investigation. We agree that in the patient at high risk of gastric aspiration the decision to use the LMA must be carefully assessed against the risks involved, but nevertheless is an option that must be considered.*

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- 2 *Priscu V, Priscu L, Soroker D*. Laryngeal Mask for failed intubation in emergency Caesarean section. *Can J Anaesth* 1992; 39: 693.
- 3 *Rabey PG, Murphy PJ, Langton JA, Barker B, Rowbotham DJ*. Effect of the laryngeal mask airway on lower oesophageal sphincter pressure in patients during general anaesthesia. *Br J Anaesth* 1992; 69: 346–8.

## Addendum

(re: Dr. Jan Davies' review of *Aftermath of Death* in the Book Review section of the May 1993 issue, page 475).

The sole North American publisher of *Aftermath of Death* (Hugh Selby, Editor) is Wm. W. Grant & Sons, Inc. of Holmes Beach, Florida. The price is \$53.00 (U.S.).

## Erratum

*Tetzlaff JE, O'Hara JF Jr, Walsh MT*. Potassium and anaesthesia. *Can J Anaesth* 1993; 40: 227–46.

Please note that the formula on page 228 should read:

$$E_k = -61.5 \log K_i/K_e$$