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Guilt by association?

Letter to the Editor:
We read with interest the article by Han *et al.*[1] on the use of laryngeal mask airway in Cesarean delivery. We agree with the editorial by Roanne Preston[2] that regional anesthesia (RA) is the preferred choice of anesthesia for Cesarean delivery. However, we disagree with Dr. Preston's assertion that Hawkins *et al.*[3] data showed general anesthesia (GA) to be 16 times more lethal than RA. David Chestnut[4] pointed out the serious limitations of the statistics and their interpretation not the least of which was that at risk patients may have received GA instead of RA.

The British have been rigorously collecting data on maternal mortality. The data is much more complete and in their most recently published triennium of 1994–96,[5] there was only one death solely attributed to anesthesia. It was a regional anesthetic.

Josten *et al.*[6] reported their experience with maternal mortality from 1988 to 1996. Of 890,422 births, there were no fatalities attributable to anesthesia. The distribution of anesthesia for Cesarean section was 60.8% GA and 39.2% RA during this time period. There is no suggestion from the German data that one technique is better than another, but that they are both safe.

We believe RA to be the preferred technique to GA but think we are doing ourselves as a group a disservice by stating there is a 16-fold lethality associated with GA over RA. This may be guilt by association, not by causality. By branding GA as intrinsically much more dangerous we encourage other health care providers, regulators, and the public to consider it reckless disregard any time we elect to, or have to, administer a GA. More hard data is needed before we can come to meaningful conclusions and statements.

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Bedside indices to predict weaning from mechanical ventilation

To the Editor:
An experienced intensivist may be able to predict whether a patient can be weaned successfully from mechanical ventilatory support or not. However, it is always helpful to have criteria on the basis of which the outcome may be predicted. After the introduction of the rapid shallow breathing index - the frequency to tidal volume ratio (breaths·min^{-1}·L^{-1}) by Yang and Tobin,[1] many studies have found it to be a very effective and simple bedside index.[2–4] In an attempt to further improve the accuracy of this index, we modified it by incorporating the weight of the patient as the ratio of frequency to the tidal volume corrected for patient's weight (breaths·min^{-1}·mL^{-1}·kg^{-1}). We hypothesized that the tidal volume corrected for the