The proper application of the principles of translaryngeal cannula ventilation can provide adequate oxygenation and ventilation, and represents a valuable alternative in emergency settings. The use of cannulae of 14 gauge or larger, connected to O_2 sources of 50 psi or greater, will maintain adequate oxygenation and ventilation. The equipment needed is not expensive nor difficult to obtain. It has been previously shown that each operating room can be easily outfitted with the proper materials,[7,11] and nothing short of this should be acceptable. We should be prepared for all emergency situations and be satisfied only when the best possible methods are used in all patients. If we depend on ingenuity in the time of crisis instead of planned alternatives, we may fail our patient.

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On Gildar's Transtracheal Ventilation System

To the Editor:—The device described by Reich and Schwartz[1] using readily available equipment for emergency transtracheal ventilation has been previously described by Gildar.[2] The simplicity of this technique, consisting of the barrel of a 10–15-cc syringe attached to the transtracheal catheter with a cuffed endotracheal tube inserted into the barrel, has much to recommend it, and the credit should go to Dr. Gildar.

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In Reply:—We appreciate the obvious interest and experimental work of Drs. Yealy and Stewart in the area of transtracheal ventilation. However, there are several points that must be clarified. Firstly, the endotracheal tube-syringe barrel device that Gildar described[1] is strictly for transtracheal oxygenation, *not* for transtracheal ventilation. Frumin, Epstein, and Cohen demonstrated in 1959 that apneic oxygenation can be maintained for periods of 18–55 min.[2] Although hypercarbia and acidosis resulted, the lowest arterial oxygen saturation obtained was 98%.

Drs. Yealy and Stewart suggest that cannulae with