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In Reply:—We thank Kubota *et al.* and Fawcett *et al.* for their comments concerning spontaneous ventilation through a large-bore intravenous catheter.

We agree with Kubota *et al.* that it is important to consider kinking of the intratracheal catheter, and we agree that the ability to suction the airway is desirable. The device that Kubota *et al.* suggest falls into the category of the large commercial "percutaneous dilational tracheostomy" appliances discussed in our case report, and most of these devices allow the passage of suction catheters. Transtracheal intravenous catheters certainly do not constitute a definitive airway, but they do provide the time required to achieve one.

We were interested in the calculations of Fawcett *et al.* of the work of breathing through various-sized catheters and their explanation that the work is an exponential function of catheter radius as predicted by the Poiseuille equation.

We wish to emphasize strongly to both Kubota *et al.* and Fawcett *et al.* that spontaneous ventilation in our patient was *via* both the large-bore intravenous catheters and some unknown residual of a chronically narrowed natural airway.

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Information Needed for Development of Practice Parameters for Difficult Airway Management

To the Editor:—The ASA Task Force on Practice Parameters for Difficult Airway Management seeks input from anesthesiologists who will be attending the IARS Meeting in San Francisco. The Task Force is developing a set of practice guidelines for management of the patient with a difficult airway.

An open forum will be held at this meeting on March 14, 1992 from 1:30 PM to 5:00 PM. You are encouraged to review the practice guidelines at this forum and to comment publicly or talk to individual members of the Task Force who will be present.

After the forum you are encouraged to provide written comments to me, at the following address.

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