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In Reply:—We question Brimacombe and colleagues' suggestion that there is "considerable evidence" that the laryngeal mask airway (LMA) has a role in emergency airway management. Although it has been suggested that the LMA is a useful device for managing emergency airway problems, the evidence to date is purely anecdotal. We are currently performing a controlled study of the LMA in managing the difficult airway in the field; however, until the results of this and other similar research are available, the suitability of the LMA for the emergency airway situation can be considered only speculative. Furthermore, adequately controlled studies in this area are exceedingly difficult to perform because of the infrequency and unpredictability with which the difficult airway is encountered.

Since we submitted our review article,[1] nearly 150 articles on the LMA have appeared in the anesthesia literature. At the time of our submission, neck immobility was regarded as a contraindication to use of the LMA.[2] We agree that recent work suggests that the inability to extend the head is not an absolute contraindication to the use of the LMA.[3] In fact, the LMA may be a very useful technique for obtaining a patient airway in these cases. However, there will continue to be situations in which the LMA cannot secure these airways (*e.g.*, it may prove impossible to advance the LMA cuff into the hypopharynx in some patients with severe cervical spine pathology),[4] and alternative techniques and equipment must be available.

The ability to perform a blind intubation through the LMA depends on the device used (*e.g.*, gum elastic bougie,[5] tracheal tube,[6] or Cook airway exchange catheter)[7] and the degree of muscle relaxation. The 30% success rate reported by Brimacombe and Berry[7] using the Cook airway exchange catheter suggests that this device is not suitable because of its rigidity and the difficulty in angulating its distal tip. In an emergency situation, it may indeed be safer to continue positive-pressure ventilation *via* the LMA (while maintaining cricoid pressure) rather than attempt to perform a blind intubation. Given the greater than 84% chance of success with a bougie or tracheal tube, a quick attempt at blind intubation is not unreasonable. However, if spontaneous respiration is anticipated to resume rapidly, it may be safer to allow the patient to awaken with the LMA in place.

We agree that the LMA is an extremely useful airway device for both routine (elective) and emergency cases. However, carefully controlled clinical trials, rather than additional anecdotal reports, are needed.

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