

Anesthesiology
82:318, 1995
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Time Required to Insert Laryngeal Mask Airway in Neonates Requiring Resuscitation

To the Editor:—We appreciate the comments by Robotham in the accompanying Highlight to our recent publication.¹ We were pleased with his evaluation that our study was clinically relevant with the potential to ultimately influence clinical management after a more extensive evaluation of the laryngeal mask airway (LMA) in the resuscitation of neonates.

At our institution, a large-scale prospective randomized application of this technique is underway to compare the LMA to bag-and-mask ventilation during neonatal resuscitation. We anticipate publication of the results following this more extensive evaluation.

However, Robotham has incorrectly stated the average time for placement of the LMA was 30 s. We feel this error must be addressed as it significantly differs from the reported value and misrepresents our results. In fact, the Materials and Methods describes that, if the LMA could not be successfully inserted and effective ventilation established within 20 s, it was to be removed. Our results reported the LMA was easy to insert with one attempt and provided a clinically patent airway in all cases. The time for insertion and establishment of effective ventilation, as displayed in table 2, was a mean (\pm SD) of 8.6 ± 1.4 s (range 7–12 s).

The time to insert the LMA and establish effective ventilation may be longer or shorter than the time needed to establish effective ven-

tilation with a bag-and-mask. The answer to this question and the clinical significance should be resolved after our current randomized trial of using the bag-and-mask *versus* the LMA for neonatal resuscitation.

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Reference

1. Paterson SJ, Byrne PJ, Molesky MG, Seal RF, Finucane BT: Neonatal resuscitation using the laryngeal mask airway. *ANESTHESIOLOGY* 80:1248–1253, 1994

(Accepted for publication October 6, 1994.)

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82:318–319, 1995
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Metal Corrosion of Tracheostomy Apparatus

To the Editor:—Recently, a 60-yr-old woman presented to our emergency department with the complaint of an inability to insert the inner cannula of a metal tracheostomy apparatus. Her tracheostomy had been placed in 1985 after a cerebral vascular accident. The patient had been managing her own tracheostomy care since the

placement of a permanent tracheostomy. On examination, the patient was breathing normally and had no signs of acute respiratory distress. On inspection of the tracheostomy apparatus, it was found that the outer cannula was missing although the retention plate was well secured around the patient's neck. Chest x-ray revealed the outer