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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 (± 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 ventilation 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

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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

Fig. 1. Chest x-ray showing outer cannula of tracheostomy apparatus lodged in right main stem bronchus.

cannula lodged in the right mainstem bronchus with the distal end 2 cm below the carina (fig. 1). Both lung fields were well aerated with no evidence of atelectasis or pneumothorax. In the operating room after routine anesthesia preparation, the stoma was anesthetized with Cetacaine topical spray, and the cannula was easily removed with a foreign-body forceps. A new #6 tracheostomy tube was inserted after careful inspection of the stoma.

A metal tracheostomy apparatus often is incompatible with anesthesia circuit connectors, requiring anesthesiologists to substitute disposable plastic cuffed endotracheal tracheostomy tubes to allow positive pressure ventilation. At this point, our specialty can have some impact in reducing potentially fatal complications of the tracheostomy apparatus, such as that described above. After removal from the patient, every metal tracheostomy apparatus should be inspected for signs of wear, corrosion, and hairline fracture, especially at the junction of retention plate and tubular components. If a metal tracheostomy tube has been in use for many years, it may be prudent to replace it, thereby circumventing the possibility of fracture. It seems plausible to prevent this complication with regular inspection and replacement of the metal tracheostomy apparatus.

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