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In Reply:—We appreciate the comments of Lambert *et al.* and apologize for incorrectly representing their work. We agree that clarification on this point is important because both laboratory and clinical data support the safety of intrathecal bupivacaine in comparison with other local anesthetic agents.

Although we are convinced of the safety of intrathecal bupivacaine, we believe that, currently, there is insufficient clinical data to warrant the total abandonment of 5% and 2% lidocaine for spinal anesthesia. Despite an incidence of transient radicular irritation of 16% in our study, all patients were recovered and completely asymptomatic at 2-week follow-up.[1] In addition, it is difficult to ignore the long safety record of intrathecal lidocaine. One of the many questions remaining to be answered is, after years of clinical use of subarachnoid lidocaine, why are we only now beginning to see patients with postoperative radicular symptoms? We agree with Lambert *et al.* that ongoing investigation is essential to answer these questions and to identify other appropriate spinal agents for practitioners seeking an alternative to lidocaine.[2]

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Airway Obstruction after Oral Midazolam

To the Editor:—I report a case of a child with congenital airway abnormalities in whom marked airway obstruction developed after administration of oral midazolam.

A 3-yr-old boy presented as an outpatient for direct laryngoscopy, rigid bronchoscopy, and possible removal of his tracheostomy. The child was born with multiple congenital cervicofacial anomalies, including subglottic stenosis, tracheomalacia, and choanal stenosis, and received a tracheostomy shortly after birth. Previous general anesthetics (without premedication) for tonsillectomy and undescended testicle were uneventful. The parents reported that he had been doing extremely well with the tracheostomy "capped" during the previous 6 months and requested that it be removed. Nighttime pulse oximetry readings (without supplemental oxygen) were consistently greater than 95%. Because it was noted on the patient's records that the child had a great deal of anxiety at the time of his previous surgery, 0.5 mg/kg oral midazolam was given in the ambulatory surgery center, and the child was then sent to the preanesthetic holding area. When I arrived to see the patient (approximately 5-10 min after oral midazolam had been given), his parents were quite concerned and claimed to me that his heartbeat and respirations were double their usual rates. On my initial inspection, the patient appeared dazed and slightly cyanotic, with severe chest wall retractions that the parents acknowledged were also abnormal. Chest auscultation revealed very little inspiratory air entry and apparent airway obstruction. Removal of the tracheostomy cap provided immediate relief. The respiratory and heart rates decreased and the cyanosis disappeared within 30 s. Oxyhemoglobin saturation was not recorded during this episode. Surgery proceeded uneventfully after induction of general anesthesia,