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In Reply:—We appreciate the interest of Rooke regarding our work[1] on myocardial oxygen demand indices. Of course regression analysis of pooled data may lead to a result different than that using regression analysis performed separately for each patient. However, the difference in results cannot be predicted because of the intersubject variability. Although in Rooke and Feigl's dog studies[2] the use of pooled values *versus* individual regression analysis resulted in an underestimation of the relative value of external work term, with different data an overestimation might have resulted. We would agree that an individual regression analysis for each patient would be interesting; however, due to the nature of our data such an approach would seem not to be valid. It is not possible under clinical conditions to perform abundant coronary blood flow measurements in patients. Therefore, in most patients only three measurements were made, and in some of the patients only two measurements were possible. Thus, an individual regression analysis does not make much sense in our data.

We appreciate the careful reading of Rooke and agree that the coefficient for the external work term in PWI modified for clinical use (PWI_{mod}) should be 8×10^{-5} and not 8×10^{-6} when cardiac index is expressed in liters per squared meter. The calculations were performed with cardiac index expressed in milliliters per squared meter, which explains the difference.

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An Armored Laryngeal Mask Airway

To the Editor:—Wilson and Eastley[1] have been forward-thinking in their use of an armored Mallinckrodt tube to reinforce a size-2 laryngeal mask airway. We are at present using a prototype armored laryngeal mask airway in the Cambridge Day Surgery Unit (fig. 1).

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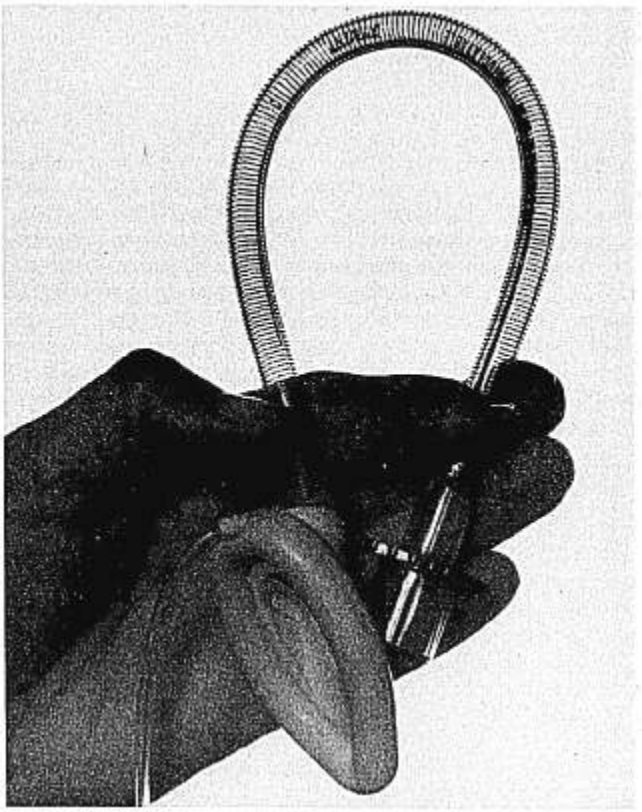

FIG. 1. The armored laryngeal mask airway (Intavent, UK).