resonance imaging to ascertain cuff position.[2] In our study, the epiglottis was within the cuff of the LMA in 88% of patients. The 12% of patients in whom the epiglottis lay outside the cuff had the LMA malpositioned. Our study and others[2,3] show that the epiglottis is within the confines of the mask in the majority of correctly placed LMAs in children. The epiglottis in children, and in the child with Pierre-Robin syndrome in our series, is actually often not at the adult anatomic position but rather is floating at an angle closer to 90° to the cervical spine.

Another minor point is that in children it is often not as easy to intubate the trachea or pass a bougie *via* the laryngeal mask. As such, we prefer to use a fiberoptic bronchoscope[4,5] to guide the endotracheal tube into the trachea, because frequently one must pass posterior to a free-floating epiglottis. However, in this case we cannot argue with Chadd *et al.*'s success.

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In Reply:—We agree with Benumof's statement "that useful techniques do not need to be mutually exclusive of one another." We also agree that all of the altenatives that he proposes are valid in most circumstances. However, in our experience, some standard approaches do not translate well technically to the neonatal and infant populations.

The use of the laryngeal mask airway (LMA) as an adjunct to fiberoptic intubation has been described.[1] We have found fiberoptic intubation *via* the laryngeal mask in infants to be limited by the short lengths of pediatric endotracheal tubes passing through the entire length of an LMA. The catheter guide was used in this case to allow removal of the LMA and subsequent placement of the endotracheal tube. We recently have described a technique that allows removal of the LMA following direct placement of an endotracheal tube with the fiberscope; this technique has eliminated our previous concerns.[2]

We have evaluated this particular catheter guide as a potential jet ventilation stylet. Because of its very small lumen and relatively long length, the flow resistance is too great to allow satisfactory jet ventilation. We show the guide in the limb of the circuit to illustrate that we did, in fact, successfully ventilate the child's lungs *via* the catheter guide, preserving access to the larynx.

As Benumof and Denman and Goudsouzian have correctly pointed out, the technique described is a blind technique[3] with the element of uncertainty that accompanies any blind approach. We believe, however, that the LMA decreases the uncertainty by effectively limiting the target of the catheter as it emerges from the LMA in the direction of the larynx. The success rate of this technique in infants remains to be systematically evaluated.

Now that we have a method of removing the LMA with an endotracheal tube in place, we also suggest that fiberoptic intubation *via* the LMA is useful in the neonatal and infant populations. We find that the LMA provides a conduit for passage of the fiberscope to the immediate area of the larynx as well as a comfortably secure route for ventilation during the process.

We appreciate the correction of the epiglottis position provided by Denman and Goudsouzian. We agree that clinically the epiglottis is most often seen to be within the LMA during endoscopy.

Our intent in reporting this case was not to advocate a technique to be exclusive of any other. We found the catheter guide to be useful in this particular circumstance. We do advocate, however, approaching the difficult airway with a careful plan that does not expose the patient to unnecessary risks of catastrophic airway loss.

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