References

1. Benumof JL: Management of the difficult adult airway. ANESTHESIOLOGY 75:1087–1110, 1991
2. Koufman JA, Little FB, Weeks DB: Proximal large-bore jet ventilation for laryngeal laser surgery. Arch Otolaryngol 113:314–320, 1987

(Accepted for publication July 14, 1993.)

Anesthesiology
79:867, 1993

A New Method of Communication between Anesthesiologists

To the Editor:—Computer systems that provide electronic mail recently became readily available. Electronic mail provides nearly instantaneous communication, making it possible to discuss safety, regulatory, or scientific matters of interest with a large number of physicians almost instantaneously. We wish to describe an anesthesiology "mailing list" that will make rapid dissemination of information possible for all members of the anesthesia community.

We have developed an anesthesiology mailing list that is open to any interested anesthesiologist, anesthesiology resident, or nurse anesthetist with no charge. It is accessible to anyone who has a computer and modem and subscribes to a computer service such as CompuServe, MCI Mail, or America OnLine. The list also is directly accessible from the Internet, a worldwide computer network. (All electronic mail addresses used below are "Internet addresses." Users of computer services mentioned above should contact their customer service department for directions about how to send electronic mail "to the Internet.") This list can be used by any member to automatically forward a message to all recipients.

All that is needed to become a member of the mailing list is to send an electronic mail message to:

listserv@mcan00.med.nyu.edu

The only line of text in the message should be:

subscribe anesthesiology

When our computer receives this message, the sender's electronic mail address will be added automatically to the mailing list. A message can be sent to all list recipients by addressing it to:

anesthesiology@mcan00.med.nyu.edu

Questions or comments about the list should be sent to

keith@mcan00.med.nyu.edu

An enthusiastic response to this invitation will result in a valuable, worldwide network of communication between members of the anesthesia community.

Keith J. Ruskin, M.D.
Instructor of Anesthesiology

Marc Tissot, M.D.
Instructor of Anesthesiology

New York University Medical Center
550 First Avenue
New York, New York 10016

(Accepted for publication July 21, 1993.)

Anesthesiology
79:867–868, 1993

A Rapid Method for Negative Inspiratory Pressure Measurement

To the Editor:—Maximal inspiratory pressure, the peak negative pressure generated against an occluded airway, is one of the most reliable methods for determining the adequacy of reversal of neuromuscular blockade.[1,2] Although older sources state that an inspiratory pressure of 20–25 cmH_2O indicates adequate recovery of neuromuscular function,[3] more recent data from fully cooperative volunteers suggest that the appropriate pressure is 40 cmH_2O.[4–6]

Although inspiratory pressure can be measured with a dedicated aneroid manometer, it usually is measured with the breathing system pressure gauge of the anesthesia machine. The generally used procedure is to remove the reservoir bag, turn off the fresh gas inflow, and close the adjustable pressure limiting (APL or "pop-off") valve. The reservoir bag mount is then occluded with the palm of one hand while inspiratory pressure is read from the gauge. The bag, APL valve,