

CORRESPONDENCE

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In Reply:—It appears that in their letter, Pond and Aiken have misinterpreted some of our results. First, one of the strengths of this study was that the “confounding variables” mentioned in the letter have all been controlled for *a priori*. Second, we did not “suggest that parental presence appeases *some* children.” This study demonstrated that children who were older than 4 yr, had a parent with low trait anxiety, or had a low baseline level of activity, as assessed by temperament ratings, benefited from parental presence during induction of anesthesia.

It is important to distinguish between “normal” childhood separation and separation in traumatic settings. A child who is left at the church nursery does not undergo (we hope) a traumatic experience of induction of anesthesia, surgery, and postoperative pain. Therefore, comparing separation for surgery to other childhood events such as separation for nursery school is inappropriate at best.

It is oversimplification on the part of Pond and Aiken to categorize all parents into two groups, those who are calm and those who are anxious. For example, among many anxious parents, there are individuals who nonetheless cope effectively with their anxiety and, therefore, can help their children with induction. When we say “Parental anxiety mediates children’s response to stressful situations . . .,” we also allow that the mediating effect may be to minimize children’s anxiety as well as potentially increase it. In addition, we do believe it is the role of the anesthesiologist to tell the parent whether they are allowed to be present during induction. From our clinical experience, parents who are overly anxious and want to participate in the induction usually withdraw their wishes once the anesthesiologist explains to them that they may actually increase the anxiety of their child.

We strongly disagree with the reasons provided by Pond and Aiken for forbidding parental presence during induction. First, there *is* proof that three subgroups of children benefit from this intervention.¹ Second, although society may tolerate some forms of normal childhood separation (e.g., church nursery), it does strongly reject other forms. For example, until the early 1960s, parents were not allowed to room with their children during hospitalization. After public pressure, it is very rare to have a hospital today that does not allow parental rooming. Do Pond and Aiken want to go back to the 1960s? Third, currently, there are no data to show that the anesthesiologist’s

job may be obstructed by this practice.² In fact, in our investigation, the rate of complications and duration of induction were similar in both groups, and a large scale study reported a very low rate of parental disruptive behavior.^{1,3} Finally, this practice is very prevalent in Great Britain and is supported (although not always implemented) by many anesthesiologists, surgeons, and parents in the United States.^{2,4,5}

In conclusion, we do not recommend parental presence for every anesthesia induction in children. The individual child, parent, and anesthesiologist should be considered whenever the question of parental presence arises.^{1,6} We do however, strongly reject the suggestion that parental presence should *never* take place.

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Extubation of the Difficult Airway

To the Editor:—Extubation over an endotracheal tube changer (ETTC) is a method used to secure the airway in a patient with a known difficult intubation. Benumof¹ describes, in detail, this procedure in his review of the management of the difficult adult airway. We found that, after extubation, the ETTC (Sheridan Catheter, Argyle, NY) becomes pliable and can be unintentionally removed from the trachea, even with careful use of the Seldinger technique. Therefore,

we confirm the correct placement postextubation by using five criteria: (1) normal ETCO₂ tracing from the distal tip *via* a CO₂ analyzer, (2) audible exhalation through the ETTC, (3) injection of 20 ml air through the ETTC to confirm the lack of presence in the mouth, (4) inability of the patient to speak clearly, and (5) chest x-ray, when the patient is transferred to the intensive care unit (fig. 1).

Patients are able to tolerate the ETTC if 1 mg/kg lidocaine is given