

CORRESPONDENCE

through these catheters," we recommended in our case report that jet ventilation through these catheters should not be necessary during the brief period of tube exchange.¹

According to the editorial of Benumof,² air entry should not exceed air exit. The incidence of complicating barotrauma may be decreased by selecting a properly sized exchange catheter in proportion to the size of the endotracheal tube, by regulating the airway pressure to low levels, and by delivering oxygen jets of short duration followed by a long expiratory pause. Also, it is important to monitor chest inflation and chest deflation both. As suggested by Dr. Haridas, jet ventilation should be discontinued the moment there is incomplete chest deflation, and there should be a high index of suspicion regarding the development of tension pneumothorax.

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Another Use for Nasopharyngeal Airway

To the Editor:—Dominguez¹ described a simple method of monitoring end-tidal carbon dioxide in spontaneously breathing adults during deep sedation. He fashioned a nasopharyngeal airway connected to a 15-mm endotracheal tube connector. This apparatus was then connected to an anesthesia circuit in the usual fashion with side-stream carbon dioxide sampling at the elbow.

This same apparatus can also be used in children with ankyloglossia for frenectomy during general anesthesia. A 20-French nasopharyngeal airway (Rusch, Duluth, GA) is connected to a 15-mm endotracheal tube connector from a 5.5-mm endotracheal tube. This device allows spontaneous ventilation, relieves airway obstruction, and allows the surgeon to work uninterrupted, as opposed to administering intermittent mask ventilation.

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In Reply:—I thank Dr. McMillon for his comments regarding his experience using nasopharyngeal airways during general anesthesia for children undergoing frenectomy. An important consideration, however, is that when using nasopharyngeal airways to deliver anesthetic

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gases, excess gas will overflow through the mouth, escaping into the environment. Even though no firm evidence suggests that trace concentration of anesthetic agents present a health hazard, there is no definitive proof to the contrary.¹ Therefore, the use of uncuffed supra-

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glottic nasal airway devices for the delivery of anesthetic gases potentially increases pollution of the operating room. This makes compliance with the National Institute for Occupational Safety and Health more difficult.²

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Comparing Combined Spinal–Epidural Analgesia with Conventional Epidural Analgesia: Were the Two Groups Identical?

To the Editor:—I read with interest the study by Tsen *et al.*¹ alleging a faster rate of cervical dilation in parturients receiving a combined spinal–epidural (CSE) analgesia in comparison to conventional epidural analgesia (2.3 ± 2.6 vs. 1.3 ± 0.71 cm/h). First-stage full cervical dilation was shortened by a mean of 78 min in the CSE group. There appear to be subtle differences between the two randomized groups. The CSE group had a lower rate of cervical dilation (2.4 ± 1.4 vs. 2.8 ± 1.4 h). Of the CSE group, 64% had initiation of Pitocin (Fujisawa, Deerfield, IL) before analgesic intervention, in contrast to only 54% of the epidural group. Finally, membranes were ruptured for 7.5 ± 5.6 h before initiation of analgesia in the CSE group but only for 5.9 ± 6.0 h in the epidural group. More frequent observed cervical examinations in one group can lead to a faster observed rate of cervical dilation. Also, oxytocin and ruptured membranes are factors that can promote a faster and more active labor. Although none of the differences were thought to be statistically significant, I believe that the faster first-stage labor may have been a result of a synergistic effect of the three different (but nonstatistically significant) variables, rather than from the type of analgesia. The authors were not troubled by the lack of regularly timed intervals for cervical examinations. I believe differently. The stage was set for the CSE group to have more active and rapid labor, leading to more frequent cervical examinations, resulting in an observational bias of faster cervical dilation. I believe that the two study groups were not optimally balanced, and a multivariate method (e.g., analysis of covariance) should have been performed.

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Another Explanation

To the Editor:—We read with interest the recent article by Tsen *et al.*,¹ who showed a more rapid cervical dilation in nulliparous women in labor who received combined spinal–epidural (CSE) sufentanil and

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This study may be misleading to our obstetric colleagues and patients. There may be a false impression that a patient's labor was prolonged because the anesthesiologist performed a "plain epidural" and not a "walking epidural." Finally, the authors neglected to address the potential risks and complications of a CSE technique. These include dural puncture, fetal bradycardia, and the lack of a tested epidural catheter. I believe further studies are warranted before conclusions can be made regarding the superiority of a combined regional technique for labor analgesia.

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