CORRESPONDENCE


Sir,—We are grateful for the opportunity to reply to the points made in these letters. The aim of the study was to assess the use of the LMA by inexperienced operators with the intention that it be available on general wards for use by nurses and junior doctors in emergencies. Training these large numbers of staff to use the device would necessarily be brief. The operators in our study had all trained at the same medical school and had received a short period of resuscitation training as undergraduates. This usually involved only a small amount of “hands on” experience of airway management. However, our proposed users in emergencies on wards would all be expected to have had a similar small amount of previous experience with face mask and bag, and perhaps not with patients. The inexperienced operators to whom Dr Tighe refers were naval medical trainees who had a short training programme using mannequins. The fact that the success rates differ reflects only that different populations were studied, and no inaccuracy can be involved to claim it with the LMA, by inexperienced group performed as well as anaesthetists, and ours did not. The group we used and the training given seemed to us to be a reasonable representation of the final ward users and the depth of training they can expect.

No specific criteria were used to exclude patients who might present with difficult tracheal intubation, but the investigators who recruited patients feared on the side of caution in their choice. None of the patients presented difficulty with intubation subsequently. Operators were shown how to use the mask and airway by demonstration by one of the investigators. Although the means of demonstration, age ranges and degree of neuromuscular block were not standardized, we feel that the crossover design of the study, with each patient being subjected to both airway management techniques in random order, effectively excluded any potential bias caused by these factors.

Reasons for failure in the mask group were not recorded, but were mainly as expected: an inability simultaneously to maintain a seal and a clear airway. All the failures in the LMA group were caused by jamming of the mask at the posterior pharyngeal wall. Times and failure rates for the first and fifth attempts for each operator were not statistically different, so no learning effect was demonstrated. It is of interest that in only two patients was the LMA successful where the face mask had failed, whereas there were 11 patients in whom the reverse was true.

The source of the 40-s cut-off time was the paper by Davies and colleagues [1]. We agree that 40 s is a very short time; however, for reasons of patient safety the time was accepted to reduce the risk of desaturation at the same medical school. This was to make in these letters. The aim of the study was to assess the use of the LMA by inexperienced operators with the intention that it be available on general wards for use by nurses and junior doctors in emergencies. Training these large numbers of staff to use the device would necessarily be brief. The operators in our study had all trained at the same medical school and had received a short period of resuscitation training as undergraduates. This usually involved only a small amount of “hands on” experience of airway management. However, our proposed users in emergencies on wards would all be expected to have had a similar small amount of previous experience with face mask and bag, and perhaps not with patients. The inexperienced operators to whom Dr Tighe refers were naval medical trainees who had a short training programme using mannequins. The fact that the success rates differ reflects only that different populations were studied, and no inaccuracy can be involved to claim it with the LMA, by inexperienced group performed as well as anaesthetists, and ours did not. The group we used and the training given seemed to us to be a reasonable representation of the final ward users and the depth of training they can expect.

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