

The high fiberoptic score using the i-gel was especially noteworthy. In only 2% of the cases, it was not possible to see the vocal cords.² In our hospital, we have a considerable number of difficult airways due to malignancies in the larynx/pharynx. Although awake fiberoptic intubation remains the gold standard in many difficult airway patients, we increasingly use the i-gel for ventilation in patients with an interdental gap of ≥ 3 cm. Once the patient's lungs are ventilated, we intubate the trachea using a flexible scope through the i-gel. When lubricated properly, an oral tracheal tube (size 7.0) can be effortlessly pushed along the flexible scope through the i-gel in between the vocal cords. Correct positioning is easily achievable using the scope. If desired, the i-gel can be removed while the tracheal tube is held in the correct place using surgical forceps. This method appears to be so successful that it is increasingly being used in our department in the case of an unexpected difficult airway. The main requirements for this technique are the use of an i-gel 4 (or 5) and an interdental gap of at least 3 cm. By using the i-gel for ventilation before tracheal intubation, one limits the number of manipulations in the larynx, thus reducing the development of swelling, hypersalivation, and potential bleeding.

Declaration of interest

None declared.

M. Sramek*

Ch. Keijzer

Amsterdam, The Netherlands

*E-mail: m.sramek@nki.nl

- 1 Theiler L, Gutzmann M, Kleine-Brueggeney M, Urwyler N, Kaempfen B, Greif R. i-gel™ supraglottic airway in clinical practice: a prospective observational multicentre study. *Br J Anaesth* 2012; **109**: 990–5
- 2 Keijzer Ch, Buitelaar D, Efthymiou KM, et al. A comparison of post-operative throat and neck complaints after the use of the i-gel and La Premiere disposable laryngeal Mask: a double blinded, randomized, controlled trial. *Anesth Analg* 2009; **109**: 1097–104

doi:10.1093/bja/aet564

Supraglottic airway devices as intubation aids

Reply from the authors

Editor—We read with interest the letter by Dr Sramek and Dr Keijzer. We are thankful for this valuable contribution. Dr Sramek correctly points out that the i-gel (and many other supraglottic airway devices) provide an excellent back-up device to fiberoptically intubate a patient with a difficult airway. It is especially noteworthy that an awake technique should remain the gold standard in expected difficult airway management. As we have shown in our study cited by Dr Sramek, there is an overlap of risk factors predicting

difficulties with i-gel ventilation and also difficulties with face-mask ventilation.¹ Therefore, unfortunately, when both standard laryngoscopy and face-mask ventilation fail (cannot intubate, cannot ventilate), there is an increased risk for difficulties with supraglottic airway device insertion and ventilation as well.

Declaration of interest

None declared.

L. G. Theiler*

R. Greif

Bern, Switzerland

*E-mail: lorenz.theiler@insel.ch

- 1 Theiler L, Gutzmann M, Kleine-Brueggeney M, Urwyler N, Kaempfen B, Greif R. i-gel™ supraglottic airway in clinical practice: a prospective observational multicentre study. *Br J Anaesth* 2012; **109**: 990–5

doi:10.1093/bja/aet565

In science, all facts, no matter how trivial or banal, enjoy democratic equality

Editor—In the alluring and rapidly expanding field of developmental anaesthetic neurotoxicity, facts have been accumulating at a tremendous rate. The overview of recent work in this area provided by Sanders and colleagues,¹ covering both laboratory and clinical studies, is therefore a welcome addition to the literature.

However, rather than providing a critical and unbiased evaluation of the all-important hypothesis—that a clinically relevant neurotoxic effect of anaesthetics exists—like most other investigators in the field, the authors approach the topic with an implicit assumption that any demonstrable effect must be meaningful. Indeed, already in the introduction, the burden of proof is squarely placed on those questioning the existence of the condition under study when the authors write, ‘these accumulating clinical data cannot exclude a clinically important effect... on cognition in later life’. In science, proof of non-existence of anything is notoriously difficult, if not outright impossible. Therefore, one must consider whether current knowledge justifies treating the clinical relevance of anaesthetic neurotoxicity as an established paradigm (and hence the demand to demonstrate its non-existence) as opposed to a hypothesis still awaiting proof.

With respect to rodent data, which constitute the bulk of available information, it is worth pointing out that most experiments were conducted using inbred strains. Inbreeding, by reducing genetic variability, may create both susceptibility to injury and limit compensatory potential, adding to the problems of extrapolating from rodent data to the human condition. Therefore, the authors appropriately highlight the importance of studies in animals other than rodents. On this background, the lenience with which the methodological deficiencies of the piglet studies are downplayed is striking: the lack