

**THE REVIEWERS WERE THINKING WISELY**

*To the editor:* We thank the author of the recent letter to the editor<sup>1</sup> for his interest in our study and would like to clarify some arguments.

We chose success rate and time to insertion as the main parameters because ventilation is possible only after successful insertion. Success rates together with insertion times are described in the first two sections of the Results and include corresponding tables. The author of the letter to the editor states that “statistical significance does not always equate to clinical significance.” We strongly agree with this statement. In the first paragraph of the Discussion, we clearly point out that “the observed mean time difference is clinically not relevant.” In the introduction, we emphasize that the “primary goal of our study was to evaluate the feasibility of insertion of different supraglottic airway devices.”

As we expected a larger time difference between the various devices, we chose time to insertion as a secondary measure. Subsequent exclusion of this variable due to an unexpected small difference does not comply with good scientific practice. We agree with the letter author that we have unnecessarily reported in

hundreds of seconds. This may be explained by the fact that Austria is a skiing nation, and we are used to this small time unit.

The author of the letter admits that “it is hard to believe that all 45 students failed to place any of five devices in other simulated pathologic conditions but were able to place the remaining two devices under these conditions.” We recommend replicating our study: seeing is more convincing than believing. If you try to use the five failing devices in the named pathologic conditions, you will break the manikin’s teeth. The problem of these devices is simply that they are relatively bulky when compared to the Combitube and the EasyTube. These devices are extremely slim, and this has been proven in patients with small interincisor distance,<sup>2</sup> excessive edema, significant secretions, tissue trauma,<sup>3</sup> and lockjaw.<sup>4</sup>

We further do not understand why it is considered negative to report that one of the authors has received royalties from Covidien in the past. It is mandatory in the medical literature to disclose any affiliations that might influence scientific work. We do not see on what grounds royalties in the past might possibly influence current

investigations. Disclosing affiliations contributes to interpreting the results and conclusions drawn by the reader in any study—sometimes one way, sometimes another. To make it easier to believe the results, the mentioned author has helped to prepare the protocol and to write the article but has not participated in any of the experiments with the students, thereby excluding any influence on the results.

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**References**

1. Eby D. What were the reviewers thinking? [letter]. *CJEM* 2013;16:8.
2. Banyai M, Falger S, Röggl M, et al. Emergency intubation with the Combitube in a grossly obese patient with bull neck. *Resuscitation* 1993;26:271-6, doi:10.1016/0300-9572(93)90148-J.
3. Mort TC. Laryngeal mask airway and bougie intubation failures: the Combitube as a secondary rescue device for in-hospital emergency airway management. *Anesth Analg* 2006;103:1264-6, doi:10.1213/01.ane.0000242521.58073.85.
4. Staudinger T, Tesinsky P, Klappacher G, et al. Emergency intubation with the Combitube in two cases of difficult airway management. *Eur J Anaesthesiol* 1995;12:189-93.