agreement with similar smaller studies from our institution\textsuperscript{2,3} and others.\textsuperscript{4}

We would like to clarify one point. The authors state in the introduction that “current best available evidence in nulliparous women . . . supports that epidural analgesia is safe in laboring women with cervix dilated 2 cm or more” and cite our study\textsuperscript{2} and that of Ohel et al.\textsuperscript{4} to support this statement. In addition, they suggest that current data do not address the effects of neuraxial analgesia when cervical dilation is less than 2 cm. This statement is not correct. Both our studies\textsuperscript{2,3} and the study by Ohel et al.\textsuperscript{4} randomized women in early labor (cervical dilation < 4 cm) to neuraxial versus systemic opioid analgesia at the first request for pain relief, no matter the cervical dilation. Indeed, the median cervical dilation at initiation of analgesia was 2 cm in our studies\textsuperscript{2,3} and the mean dilation was 2.1 cm in the study by Ohel et al.,\textsuperscript{4} meaning that 50% of the study populations had cervical dilation 2 cm or less at the initiation of analgesia. Therefore, we disagree with Wang et al. that data do not exist to support the practice of initiating neuraxial labor analgesia when cervical dilation is less than 2 cm.

We are also concerned about the reporting and interpretation of the data regarding one of the secondary outcomes, duration of labor.\textsuperscript{1} The duration of labor and duration of neuraxial analgesia in the study by Wang et al. are significantly longer (hours) than that in our studies of spontaneous\textsuperscript{2} and induced\textsuperscript{3} labors, and in the study by Ohel et al.\textsuperscript{4} with a mixed parity population. In table 2, the outcome of interest is listed as “Length of labor (from analgesia request to vaginal delivery), h§.” However, in the footnote to the table, the symbol “$^\S$” is defined as the length of labor starting from the onset of regular uterine contractions to the time of delivery of the placenta. The text describing the results of the Kaplan–Meier duration of labor analysis indicates that duration was defined as the interval from analgesia request to delivery. However, it is unclear why the median duration of epidural analgesia is 12.6 h in the early (latent phase) neuraxial analgesia group (table 2); but, the median duration of labor from analgesia request is 627 min (10.5 h; fig. 2A\textsuperscript{1}).

In our studies, we defined duration of labor as the time from analgesia request until delivery (~7 h),\textsuperscript{2} and Ohel et al.\textsuperscript{4} defined the duration of labor as the time of randomization until delivery (~6 h). This distinction is important for two reasons. First, the timing of the first regular contraction is hard to specify, and we suggest that pinpointing this time is subject to considerable bias. Second, both we\textsuperscript{2,3} and Ohel et al.\textsuperscript{4} found that the duration of labor was significantly shorter in women randomly assigned to early neuraxial compared with early systemic opioid analgesia, whereas Wang et al.\textsuperscript{1} did not. We suggest that the investigators cannot ascertain the effect of early labor analgesia on duration of labor by using the time of onset of regular contractions as the start time of labor. The ill-defined and likely highly variable interval between onset of regular contractions and the actual therapeutic intervention (initiation of analgesia) may obscure any differences that may have occurred because of the intervention. To ascertain the effect of an intervention on the duration of labor, the start time must be close to the time of the interven-

References


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In Reply:

We appreciate the interest of Drs. Wong, Scavone, Sullivan, and McCarthy in our work\textsuperscript{1} and thank them for their comments. The association between neuraxial analgesia at different stages of cervical dilation and the risk of cesarean delivery is an important issue and has been debated for decades. We performed a 5-yr randomized controlled trial, initiated in January 2003, to investigate the hypothesis that early epidural analgesia at cervical dilation of 1.0 cm or more would not increase the risk of cesarean delivery or prolonged labor, and found results that were consistent with those reported by Wong et al.\textsuperscript{2,3} and Ohel et al.\textsuperscript{4}

In our study, the median diameter of cervical dilation was 1.6 cm (interquartile range, 1.1–2.8 cm) in the early epidural analgesia, which was smaller than that reported by Wong et al. (median, 2.0 cm) or Ohel et al. (mean, 2.1 cm). In our publication, we described published data regarding neuraxial analgesia at a cervical dilation of 2.0 cm and which provide

Supported in part by grant ZKXX07021 from the Nanjing Municipal Medical Science Development Foundation, Nanjing, Jiangsu, China, and grant NY0572 from the Science and Technology Development Foundation of Nanjing Medical University, Nanjing, Jiangsu, China.
support for the use of epidural analgesia in nulliparous analgesia. In the description, we did not precisely and explicitly state cervical diameter, which resulted in a misunderstanding by these authors that our citations were incorrect. We apologize for this confusion. In addition, these previous publications included primarily a Western population, and it is uncertain whether the results would be similar in an Asian population. Therefore, we did our trial to test the effect of early epidural analgesia at a median cervical dilation less than 2.0 cm on the risk of cesarean delivery in Chinese women.

In addition, Wong et al. point out that our definition of the length of labor in the table was inconsistent with the footnote explanation in table 2 of our article. The authors are correct, and we have requested that a correction be published, which will appear in an upcoming issue of this journal. We clarify again that, in our study, the length of labor refers to the period from the onset of regular uterine contraction to the time after delivery of the placenta. Using this definition point, there was no statistically significant difference in the length of labor between groups. Moreover, the analgesia time in both groups was longer than the labor time, mainly because epidural analgesia was not stopped until about 1 h later after the placenta was delivered to reduce early postpartum pain resulting from uterine contraction or perineal trauma during delivery.

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References

(Accepted for publication January 8, 2010.)

Sensory Nerve Damage after the Use of the LMA Supreme™

To the Editor:
The LMA Supreme™ (Laryngeal Mask Company Limited, Le Rocher, Victoria, Mahe, Seychelles) is the first and only single-use laryngeal mask airway (LMA) with gastric access that combines the desirable features of the LMA-Fastrack™, LMA-Proseal™, and LMA-Unique™. Until now, no adverse effects have been reported related to its use. We report on a 64-yr-old woman (height, 174 cm; weight, 68 kg) scheduled for breast-conserving surgery for breast cancer. After general anesthesia induction with boluses (2 mg/kg of propofol and 1 µg/kg of remifentanil over 30 s), the patient’s lungs were ventilated using a facemask for 2 min. A size 4 LMA-Supreme™ was chosen according to the manufacturer’s guidelines and inserted at the first attempt using a one-handed rotational technique with the patient’s head in the semisniffing position. The LMA-Supreme™ cuff was inflated to and maintained at 60 cm H2O. No air leaks were detected. The LMA-Supreme™ was secured to the patient’s face with adhesive tape, according to manufacturer’s instructions. Anesthesia was maintained with infusion of propofol (6 mg·kg⁻¹·min⁻¹) and remifentanil (0.2 µg·kg⁻¹·min⁻¹). The lungs were ventilated with an oxygen–air mixture (fraction of inspired oxygen 0.3). A tidal volume of 600 ml was administered through volume-controlled ventilation with a peak airway pressure of 14 cm H2O. Ten minutes after insertion of the LMA-Supreme™, peak airway pressure increased from 14 to 18 cm H2O and a 20% leakage occurred. The anesthesiologist repositioned the LMA-Supreme™ by gently moving it further inward into the pharynx until the air leaks ceased and refixed the device in the new position with the fixation tab (FT) in contact with the patient’s upper lip. The surgical procedure lasted 80 min. The patient was then awoken and LMA-Supreme™ removed. The patient complained of a slightly swollen upper lip with sensory loss to the midline that was confirmed by examination. Neurologic findings corresponded to a pressure damage in the infraorbital nerve, a branch of the maxillary nerve (second branch of the trigeminal nerve), which innervates the upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.

LMA-Supreme™ is a new ventilatory device with innovative constructive features such as the FT that, although generally favorable, requires special attention. For example, the FT is a rectangular structure molded onto the manifold at right angles and it projects over the patient’s upper lip. The complication started to improve after a week and regressed completely after 14 days.