way (LMA) over the conventional endotracheal tube including decreased cardiovascular responses during insertion.[5-8]

We used the LMA in two patients with anterior communicating artery aneurysm, aged 50 and ;62 yr. Clipping of aneurysm was done on the 34th and eight post-bleed day. There was no history of any other systemic illness. Preoperatively patients were conscious and oriented. Patients were receiving nimodipine 60 mg six-hourly, phenytoin 100 mg eight-hourly *po* and dexamethasone 4 mg eight-hourly *im*. Premedication was with diazepam. After meperidine 50 mg *im* the radial artery was cannulated under local anaesthesia and baseline values of heart rate and blood pressure were recorded. Anaesthesia was induced with thiopentone 350 mg and three minutes after vecuronium, a # 4 LMA was introduced. Anaesthesia was maintained with $N_2O$, 66% in $O_2$ and the lungs were ventilated to maintain $ETCO_2$ at 32 mmHg. Monitoring of heart rate (HR), ECG, Minimal increases in systolic arterial pressure (SAP), mean arterial pressure (MAP) diastolic arterial pressure were observed during insertion of LMA and throughout the surgical procedure. Emergence was very smooth. Postoperatively, patients were fully conscious and their subsequent course at the hospital was uneventful.

The LMA can be therefore used in place of ETT in aneurysm surgery to achieve haemodynamic stability. However, there are a number of concerns with the use of an LMA. Could a further decrease in $PaCO_2$ be achieved with the LMA? Another concern is gastric distention. Displacement of the LMA, especially in a setting with no access to the head and neck could be difficult to manage. We suggest that the LMA be considered as an alternative to tracheal intubation in intracranial aneurysm patients where difficult intubation is anticipated.

Anil Agarwal MD
Shobhna Rajan MD
Department of Anaesthesiology and Critical Care Medicine
SGPGIMS, Lucknow, 226 014
India.

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# *Publishing and the Internet*

To the Editor

The recent expansion of internet information services has provided a fascinating new avenue for exchange of information, in the field of medicine. This resource can currently be considered in its infancy, and continued development is sure to lead to greater use by a growing number of anaesthetists worldwide. Currently, most of the material appearing on the internet is not peer-reviewed (an exception is "Educational Synopsis in Anesthesia" published electronically each month by K. Ruskin and edited by a panel headed by D.J. Doyle.) The inevitable question that arises is: does publication of material on the internet constitute duplicate publication, if this same material is presented elsewhere in a printed format? The answer to this question may not be as simple as it first appears. Material can be presented in many ways on the internet, and can take various paths to it. For example, an article in development may be presented, allowing for critical appraisal by email, before it is submitted to a peer-reviewed journal. Alternatively, a published article could be reproduced electronically as a WWW (world wide web) page, with the original reference cited. Many other scenarios exist. As part of the growth of this new information resource, we believe clear publication guidelines are needed worldwide to ensure the academic integrity of anaesthesia internet information. We very much welcome comments and guidance regarding this most important issue.

Peter Duffy MD FRCPC
Donald Miller MD FRCPC
Department of Anaesthesia
Ottawa General Hospital
University of Ottawa.