Secondly, given the heterogeneity of surgical models, a random effects model may, indeed, have made more sense from a clinical perspective. However, it could equally be argued that the pain model was the only difference between studies, with all other aspects being clinically homogenous: we included clinical trials of high reporting quality that studied patients with similar levels of initial pain intensity and used consistent methods of measuring pain over the same time periods. Additionally, while not stated in the text, we performed a sensitivity analysis using a random effects model. None of the estimates for the primary outcome changed in direction, statistically significant analyses remained as such, and changes in effect size were minimal. However, 95% confidence intervals were, predictably, generally wider. For example, the combined NNTs (95% confidence intervals) for at least 50% pain relief at 4 h were 3.7 (2.6–6.7) when applying a random effects model as opposed to 4.0 (3.4–5.0) when our original method of analysis was applied. Finally, we agree that duplicating the number of patients in a placebo group between two comparisons may generate a unit-of-analysis error. As Sahgal and colleagues point out, there are several methods of addressing this. We chose the simplest method—splitting the shared group—and, as with our other sensitivity analyses, found clinically insignificant differences in point estimates and variances and no difference in statistical significance. For example, the combined NNTs for at least 50% pain relief at 4 h were 4.3 (3.6–5.3) when splitting the shared group as opposed to 4.0 (3.4–5.0) when the patients were duplicated. We hope that this additional information adequately addresses their concerns and further contributes to the understanding of a complex systematic analysis of the literature such as ours.

**Conflict of interest**

E.M. has consulted for Javelin Pharmaceuticals, Wyeth, and Ortho-McNeil-Janssen Pharmaceuticals. M.S.C. is an employee of Johnson & Johnson Pharmaceutical Research & Development. Johnson & Johnson Pharmaceutical Research & Development is an affiliate of Ortho-McNeil-Janssen Pharmaceuticals, Inc., which markets several analgesic drug products including opioids and over-the-counter analgesics such as acetaminophen. She participated in the design of the study, before she joined Johnson & Johnson Pharmaceutical Research & Development.

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doi:10.1093/bja/aer283

**Consent of subjects for general anaesthetic in Caesarean section**

Editor—We read with interest the paper by Park and colleagues1 regarding attenuation of the cardiovascular response to tracheal intubation using a bolus dose of remifentanil. While we commend the authors for trying to find pharmacological answers to a difficult clinical question, we felt that it remained unclear quite how patients were selected for this study and we would question the necessity of all these women undergoing general anaesthesia (GA) for Caesarean section. The authors state that ‘a total of 48 women with severe PET undergoing elective or urgent Caesarean delivery under GA were enrolled’. They then went on to discuss lower segment Caesarean section (LSCS) under regional anaesthesia and state that women were consented for GA. There is no mention of counselling women as to the possible benefits and risks of regional anaesthesia balanced with those of a general anaesthetic. It worried us on reading this paper that it was not made clear whether women enrolled in this study had been given full disclosure of the anaesthetic options available to them. In this day and age, it is widely acknowledged that, where possible, regional anaesthesia is the preferred mode unless there are specific contraindications (e.g. severe PET with coagulopathy, maternal refusal, urgency of the situation). One of the greatest risks of all being the very thing they were studying, namely surges in arterial pressure that can result in disastrous consequences coupled with the possible risk of airway complications. They have also justified their use of GA for LSCS in some of the study group as indicated by fetal distress. However, we would argue that if Caesarean section needed to be expedited then it is likely a spinal anaesthetic would have been a minor delay in comparison with the rest of the set-up required for such a study to take place. It may well be that all of the study group had a coagulopathy so severe that regional anaesthesia was contraindicated or that each of the women made an informed decision to refuse regional anaesthesia and if this is the case, it would have been preferable if it had been clearly stated in the publication. To omit such details is potentially misleading. We write seeking clarification on this issue as we feel it is an important aspect of such a study.

**Conflict of interest**

None declared.
that whether the regional anaesthesia has advantages for both the mother and baby over general anaesthesia has yet to be determined in East Asia.

Conflict of interest

None declared.

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Tracheal intubation with the direct and indirect laryngoscopes in patients with cervical spine immobilization

Editor—In a randomized, controlled clinical study in patients with cervical spine immobilization, McElwain and Laffey1 demonstrated that intubation performance of the Airtraq laryngoscope produced a reduction in the Intubation Difficulty Scale (IDS) score, improvement in the Cormack and Lehane glottic view, and decrease in the need for optimization manoeuvres, compared with both the Macintosh and C-MAC laryngoscopes. In addition to the limitations described in the discussion, there are additional issues affecting the conclusions of this study.

First, a significantly better laryngeal view was obtained with the Airtraq laryngoscope compared with the Macintosh and C-MAC laryngoscopes. However, the authors did not provide the blade sizes of the Macintosh and C-MAC laryngoscopes used in this study. We would like to know whether a single size blade was used for all patients in the Macintosh or C-MAC group. The C-MAC laryngoscope has two Macintosh blades (sizes 3 and 4) available for the adult patients. The size 3 blade, it is preferred for daily practice. The size 4 blade is more curved, resulting in a higher angulation with a wider view of the glottis, which may be advantageous if