spondyloepiphysial dysplasia tarda, and campomelic dysplasia deserve further comment.

The authors state in the appendix that patients with pseudochondrodysplasia have normal cervical spines. This is in direct contradiction to one of the cited appendix references and also conflicts with earlier work by one of the authors. In both of these references, odontoid hypoplasia is noted in pseudochondrodysplasia, and Perovic et al. reported that three of their four patients with this combination of findings had cervical spine instability. Similarly, patients with diastrophic dysplasia and spondyloepiphysial dysplasia tarda are noted by Berkowitz et al. as having normal odontoid processes or completely normal cervical spines, respectively. Odontoid hypoplasia and its attendant problems are less common in these patients than in those with one of many other types of disproportionate dwarfism, but they have been reported. Other cervical spine problems are mild but may progress over time. Finally, patients with campomelic dysplasia virtually always have cervical spine problems, often severe. Preoperative evaluation of the cervical spine, including complete odontoid evaluation, is important in all of these patients, especially considering the likelihood of difficult intubation. Practitioners encountering a patient with any disproportionate dwarfism are well advised to be extremely conservative in their approach to the cervical spine and to intubation.

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In Reply:—Dr. Audenaert has correctly pointed out misquotations in the appendix of our review in regard to cervical spinal abnormalities of patients with pseudochondrodysplasia, diastrophic dysplasia, spondyloepiphysial dysplasia, and campomelic dysplasia. We agree with his comment that the preoperative evaluation of the cervical spine is important in the above groups of patients as well as in other patients with disproportionate dwarfism.

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An Aid for Simultaneous Instructor and Trainee Viewing of Orotracheal Intubation

To the Editor:—Tracheal intubation is among the most important techniques that anesthesia trainees learn during graduate medical education. Yet anyone who has attempted to teach this skill and to view laryngoscopy from a distance (e.g., over the shoulder) knows how difficult it is to confirm just exactly what the student is visualizing. We report a simple modification of readily available tools that will assist those teaching laryngoscopy and tracheal intubation while affording a continuous and direct view of the procedure.

A standard curved laryngoscope blade is modified (fig. 1) by drilling two sets of 1.5-mm holes to allow attachment of an intubating fiberoptic bronchoscope (Olympus LF-1). Each parallel set of holes is 4–5 mm apart, with the sets distanced 5 and 9 cm from the tip of the blade. The fiberoptic bronchoscope is attached loosely through these holes with rubber bands, still allowing some flexion of the scope’s tip. Assembled prior to induction, the blade is attached to a standard handle and the bronchoscope attached to a light source. Once placed into the oropharynx by the student, the teacher may follow exactly where the laryngoscope travels. No oral airway is required to protect the fiberoptic attachment, since the laryngoscope prevents jaw closure. Several advantages are noted with this apparatus: Lighting conditions are supplemented by the attached fiberoptic light source compared to the traditional battery handle, providing maximal viewing. The teacher can scan (roughly a 75° field of view with a 240° arc, for the Olympus LF-1) the periglottic area to note abnormalities the student might miss.