

CORRESPONDENCE

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In Reply:—Waskell believes she should not alter her practice based upon our paper, citing the fact that rates of amputation were not statistically different before discharge. Amputation is performed for a number of possible indications other than inadequate tissue perfusion, e.g., infection. It may be performed even when the graft is patent. Therefore, it is a less specific outcome related to graft patency than is reoperation.

Patients who must undergo reoperation, especially those with atherosclerotic vascular disease, are placed at significant risk, including major cardiac morbidity and death. Therefore, our finding of an increased rate of reoperation after general anesthesia should lead many anesthesiologists to favor epidural anesthesia.

Waskell also points out that the 6-month vascular surgery outcome was not different in the two groups. This is true as reported on table 2 in the paper.¹ However, by a lifetable-type analysis similar to that shown in figure 2,¹ the difference in outcomes at 6 months was significant ($P = 0.047$). This is because the rate of subsequent events remained similar for the two groups, as in figure 2 for the 1-month outcomes.¹ The difference in outcomes that was evident within the first 10 days after surgery never disappeared. It only diminished in

importance relative to the high overall rate of reoperation. Many anesthesiologists would consider a reduction in perioperative graft failure a reason for modifying their practice.

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Reference

1. Christopherson R, Beattie C, Frank SM, Norris E, Meinert C, Gottlieb S, Yates H, Rock P, Parker S, Perler B, Williams GM: Perioperative morbidity in patients randomized to epidural or general anesthesia for lower extremity vascular surgery. *ANESTHESIOLOGY* 79: 422-434, 1993

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An Alternative Light Source for Laryngoscopy

To the Editor:—I would like to point out a useful technique for tracheal intubation in the patient with a bleeding tonsil or similar type of airway emergency.

In the past, while attempting to intubate the trachea of a child with a bleeding tonsil, I have found the laryngoscope bulb nonfunctional as the result of blood covering the lamp. Depending on the circumstances, almost complete loss of vision is experienced and landmarks cannot be visualized. Changing blades or laryngoscopes takes time, and the problem may recur. Secretions tend to do the same thing, but they are not as problematic as blood because the latter is more opaque. This problem could occur where there is pulmonary hemorrhage, and so on.

A technique that has worked well for me in dealing with this sit-

uation is as follows. Before induction, a headlight is secured in place and adjusted to the proper angle. Induction is carried out in the usual fashion, and laryngoscopy is performed using the headlight as the light source along with the usual laryngoscope blade light, if it functions properly. Vision of the cords and surrounding structures is good to excellent, even without light from the blade.

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A Matter of Degree¹

To the Editor:—In 1674, Nicolas Boileau-Despréaux wrote, "Folly in all of every age we see, the only difference lies in the degree."² With all "deference due to a Man of Head Degree,"³ the folly I would

like to address here is ANESTHESIOLOGY'S unique penchant for expressing temperature units in the form, "37° C."

Degrees on the Centigrade scale are analogous to millimeters of