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In Reply:—We agree with Dr. Rigg *et al.* that large multicenter randomized trials are required to address most clinical outcome questions and that selection of "high-risk" patients will improve the power of such studies. We choose to study our peripheral vascular surgery patients because they were considered to be "high risk." In our study, 85% of the patients were diabetic, 69% had hypertension, and 36% had a history of previous myocardial infarction.[1] In another prospective study conducted at our institution, 100 consecutive diabetic patients scheduled for vascular surgery received thallium imaging studies before surgery. Eighty percent of these patients had thallium defects, with an average of 1.8 reversible defects per patient.[2] We would have had to perform additional preoperative cardiac testing, such as persantine thallium or dobutamine stress echocardiography, on all enrolled patients to select an even higher risk subset, which by itself would have represented a major financial and logistical challenge.

Rigg *et al.* suggest that a multicenter trial with sufficient power to determine if choice of anesthesia has any influence on cardiac morbidity and mortality in peripheral vascular surgical patients is a "realistic and achievable" goal. We respectfully disagree. First, as discussed previously, it would be difficult to cost-effectively select a substantially higher risk group. Second, there are relatively few centers in the industrialized world that have the volume of high-risk peripheral vascular patients seen at our hospital. Third, if our study could be considered a pilot, it offers little encouragement to those investigators willing to undertake a larger study in hope of demonstrating any differences.

We also would like to correct a statement made by Rigg *et al.* They stated that postoperative epidural analgesia was not used in our study. As we previously have reported, 40% of the patients in the epidural group had epidural morphine, and there was a trend toward a higher myocardial infarction rate in that subgroup.[3]

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Use of the LMA for Management of Difficult Airway Due to Extensive Facial and Neck Contracture

To the Editor:—The laryngeal mask airway (LMA) provides an alternative technique for managing difficult airway scenarios.[1,2] We would like to report a case of compromised airway resulting from an extensive severe postburn contracture and its subsequent management.

During a medical humanitarian mission to the West Bank of Palestine, a 32-year-old woman, ASA physical status 2, presented with severe extensive neck contracture that affected the neck, the chin, and the lower lip. The contracture was a result of an untreated partial and full-thickness thermal burn because of the ignition of clothing during a house fire. Surgical reconstruction had been scheduled 1 year previously, but the operation was cancelled because of failure of conventional orotracheal intubation. Because of psychological disturbances and apparent limited intelligence, attempts to establish satisfactory rapport with the patient was unsuccessful. Consequently, we did not believe that an awake blind nasotracheal intubation was an option.[2] Also, the retrograde technique (translaryngeal-guided intubation) was not attempted because of anatomic deformity resulting from the extensive neck contracture.

After preoxygenation, anesthesia was induced with propofol and fentanyl, and the lungs were ventilated manually with oxygen and halothane by a size 4 face mask without particular difficulty. Laryngoscopy with a Macintosh laryngoscope (blade 3 and 4) was attempted twice, but the larynx could not been seen. Because the facilities for an alternative intubation (*e.g.*, new laryngoscope blades, illuminating intubating stylets, flexible fiberscope) were not available, a LMA, size