anesthetic within the subarachnoid space may be associated with this neurologic symptom. Our results indicate that a subsequent injection at the same interspace after a failed spinal anesthesia has the risk of neurologic injury. A subsequent injection should be attempted at a higher interspace to avoid reinforcing the same restricted distribution.[2] In addition, a combined dose that exceeds the standard recommendation for single-injection spinal anesthesia still has risk of injury, even if a different interspace is used, and hence other modifications, such as altering patient position, using an anesthetic with a different baricity, or straightening the lumbosacral curvature, should be considered.[1]

Yoshihiro Hirabayashi, M.D.
Lecturer
yhira@jichi.ac.jp
Ruriko Konishi, M.D.
Instructor
Reiju Shimizu, M.D.
Professor
Department of Anesthesiology
Jichi Medical School
Tochigi, Japan

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Laryngeal Mask Airway Fitted over a Tracheotomy Orifice: A Mean to Ventilate a Tracheotomized Patient during Induction of Anesthesia

To the Editor:—It is occasionally difficult to ventilate a tracheotomized patient. In such a patient, controlled ventilation through a face mask is difficult. Some patients can easily tolerate topical anesthesia and awake insertion of an endotracheal tube through a tracheotomy orifice, followed by the anesthesia. However, for those who cannot, deep anesthesia and muscle relaxation before tube placement may be preferable.

In such a situation, ventilation using a small laryngeal mask fitted over a stoma has proven to be a reasonable solution (fig. 1). With this method, we can easily ventilate a patient and control the depth of anesthesia.

Ventilation *via* a tracheostomy using a pediatric mask over the stoma has been reported previously.[1] Unfortunately, in some cases, it is difficult to fit a pediatric mask because of a hollow between clavicles, the sternum, and sternocleidomastoid muscles. In such cases, the use of a small laryngeal mask airway may be of value.

Yasuhiro Morita, M.D.
Resident
Makoto Takenoshita, M.D.
Assistant Professor
Department of Anesthesiology
Osaka University Medical School
Osaka, Japan
makoto@anes.med.osaka-u.ac.jp

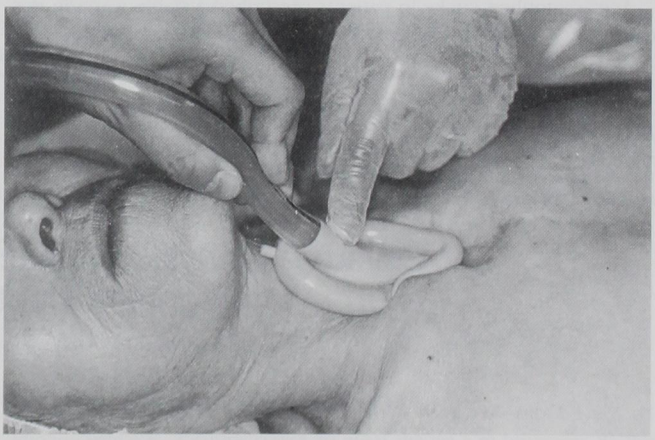

Fig. 1. Laryngeal mask fitted over a tracheotomy orifice.

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