

CORRESPONDENCE

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A Hairy Situation

To the Editor:—As a bearded anesthetist, I was interested to read the solution of Drs. Johnson, Bradway, and Blood to the problem of good mask ventilation in the presence of an hirsute face.¹ Although they are correct in their assertion that it is a frequently encountered situation, they are incorrect in their statement that the only previously published solution has been to shave the patient preoperatively. In Great Britain, we are often accused of lagging behind our transatlantic colleagues, especially where high-technology medicine is concerned. However, the technique that Johnson suggests of applying a clear intravenous site dressing is similar to the use of a cut defibrillator pad, which was suggested in a recent correspondence about in the journal *Anaesthesia*.² An added advantage of using defibrillator pads is that an urgent shout for them attracts the attention of nearby staff, who might otherwise be preoccupied. Other ideas presented in the correspondence include (1) the use of plastic kitchen wrap around the entire head, which is not to be used with an unstable cervical spine,³ and (2) placing the caudal end of the mask between the lip and the alveolar ridge, which is also useful in the edentulous.⁴

Facial hair also has been reported to be a cause of difficult intubation because of a handlebar moustache obscuring the view of the larynx. The solution in this case was to force the moustache flat with adhesive

tape. Reflection on these anesthetic problems has made me decide to invest in a new razor.

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Difficult Mask Ventilation

To the Editor:—Dr. Johnson *et al.*¹ describe a useful method to reduce gas leaks from the face mask in bearded patients and thus enable adequate oral positive-pressure ventilation *en route* to tracheal intubation.

In this type of situation, one can also opt to avoid the oral route entirely and attempt nasal positive-pressure ventilation instead, using a smaller, clear, padded mask (*i.e.*, the size of a toddler, an infant, or even a neonate mask). Using this technique, the mouth is kept firmly closed and the head is extended. The mask covers the nostrils but does not extend beyond the upper lip. By reducing the surface over which ventilation occurs, the potential for leakage of anesthetic gas may be reduced. Furthermore, the airway often is easier to support if the mouth does not have to be kept open.

Nasal positive-pressure ventilation can be an effective mode of ventilation in edentulous patients when conventional mask ventilation fails because of excessive gas leakage from the mask. It may also be a useful

mode of ventilation in the bearded patient. An occasional problem is leakage of gas from within the mouth, but this leakage is usually not serious enough to compromise ventilation.

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In Reply:—The publication of several letters to the editor concerning management of the bearded airway occurred concurrent to the formulation of our correspondence¹ and were regretfully excluded from the discussion and references. This flurry of furry correspondence in the journal *Anaesthesia* highlights the ubiquity of the problem, and also the range of solutions, depending on the resources that are available.²⁻⁷

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Aseptic Meningitis after Spinal Anesthesia in an Infant

To the Editor:—We read with interest the report by Easley *et al.*¹ of aseptic meningitis after spinal anesthesia in an infant. Although the report is a poignant reminder that this complication is a risk when performing spinal anesthesia in any patient, adult or neonate, we have several concerns. First, the differential diagnosis between viral meningitis and aseptic meningitis is, at best, difficult to make. Based on the authors description of the cerebrospinal fluid findings, diagnosis does not rule out viral meningitis.² Second, in the concluding paragraph, the authors state that they suspected aseptic meningitis, but could not prove a causal relation.¹ As illustrated in a recent report of two infants who were diagnosed with meningitis—one after and one immediately before placement of a spinal anesthetic—the onset of meningitis may be coincidentally timed with the induction of the spinal anesthetic.³ In such cases, the causal relation between aseptic meningitis and the spinal anesthetic should be a diagnosis of exclusion. We believe that viral meningitis was not ruled out in the report by Easley *et al.*¹

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