CORRESPONDENCE

cannot agree that this was “despite meticulous aseptic techniques”. It is clear that whoever gave the anaesthetic did not wear a surgical facemask. I believe that the anaesthetist should always wear such a mask when performing a central nerve block. During both preparation and needle insertion, the anterior nares and mouth are relatively close to, and usually immediately above, the sterile field. The arguments put forward in defence of the practice of not wearing a mask are based primarily on studies of ward practice and may not be relevant. The effect of contamination, especially with particulate matter, may be more significant because any bacteria that do gain access are placed in an ideal culture medium, which is relatively deficient in host defence mechanisms. Bacteria can, as this case shows, multiply very rapidly in that situation. In my opinion, a mask should be worn.

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REFERENCES

Sir,—Thank you for the opportunity of replying. I agree that all the standard texts advocate drawing Tuffer's line on the subject's back. However, it is my experience, gained in several units and from watching many practitioners, that extradural needles are frequently sited by lying the patient on the side, palpating the upper iliac crest and running the hand down to the vertebral column, rather than palpating both iliac crests and joining them. It is precisely this need for meticulous attention to detail that I was trying to convey.

Regarding the comments concerning the risk to the spinal cord. I did not intend to imply that thoracic extradural blocks are dangerous. Rather, I was trying to draw attention to the fact that intradural needles, if sited higher than anticipated, might put at risk a cord terminating lower than normal.

F. A. Ievins Solihull

FAILED TRACHEAL INTUBATION

Sir,—Dr King and Professor Adams correctly state that the Laryngeal Mask Airway (LMA) has been used successfully after failed intubation at Caesarean section [1, 2]. However, if a decision is made to insert the LMA in the obstetric patient we would question the timing of insertion, which they state should be after spontaneous ventilation has resumed.

We would suggest that when failure to intubate has been acknowledged, and in the unfortunate situation that the patient's lungs are difficult or impossible to ventilate manually, the LMA should be inserted at that time rather than wait until the gravity of the situation has rectified itself by resumption of spontaneous ventilation. Alternatively, in the hopefully rare situation when it is felt that surgery must proceed in the patient in whom it is impossible to intubate the trachea, but who has a reasonably clear airway, it might be prudent to pass the LMA in the still paralysed patient before spontaneous ventilation has resumed, as insertion of the LMA might be technically more straightforward.

The correct use of the LMA provides a safer means of maintaining ventilation before last-ditch attempts at cricothyroid puncture or tracheotomy.

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REFERENCES

TRACHEAL INTUBATION WITH THE PATIENT IN A SITTING POSITION

Sir,—Occasionally, the anaesthetist is required to provide general anaesthesia for a patient with a difficult airway and a full stomach. In some instances, these patients may have concurrent cardiovascular or cerebrovascular disease or increased intracranial pressure, and would benefit from a smooth intubation technique that prevents wide variations in cardiovascular variables. With adequate topical and regional anaesthesia of the airway, the cardiovascular responses to laryngoscopy and intubation may be minimized; however, the risk of silent aspiration is greatly increased.

Before the availability of the fibreoptic laryngoscope, the preferred technique was an awake intubation. Topical anaesthesia and sedation were kept to a minimum in an attempt to maintain the protective laryngeal reflexes and decrease the