downwards. Clearly there was a haematoma present, but I wonder if, in fact, this arteriopathic patient thrombosed the artery of Adamkiewicz at T5 and thus suffered a spinal "stroke". The absence of pain would support such a diagnosis.

J. A. W. WILDSMITH
Edinburgh

REFERENCE

CORRESPONDENCE
Sir,—We are grateful for the opportunity to respond to Dr Wildsmith's letter. We stress the fact that the case report arose from a neurosurgical department and was interesting because no such case has been treated at our institution over a 30-year period.

The patient was transferred from another university hospital, therefore we cannot comment on the experience of the anaesthetist. The information was gathered from the anaesthesia records and patient charts. According to the records, the administration of heparin was discontinued, not before catheter removal, but immediately after the occurrence of paraplegia. We have found no record of reversal.

The reply to the question of catheter insertion and haematoma level may be found in the first paragraph of the case report: "... a single puncture at L2-3 level..." and "...catheter was passed about 2-3 cm beyond the tip of needle...". The confusion seems to arise as to the level of anasthesia detected at our institution some 14 days later, when both ascending and descending cord oedema developed which was evident on T2-weighted MR images not included in the report.

In reply to the final point, a spinal angiogram during evaluation of our patient was found not only unnecessary, but would have been dangerous, therefore any suggestions of thrombosis of the artery of Adamkiewicz can only be speculative. Nevertheless, we think it is unlikely even for an arteriopathic patient to develop thrombus whilst undergoing i.v. anticoagulation.

We thank Dr Wildsmith for the opportunity to supplement the information on this rare and unfortunate case.

I. H. TEKKOK
O. CATALTEPE
K. TAHHA
V. BERTAN
Ankara

DIFFICULT LARYNGOSCOPY
Sir,—For the results of studies on difficult laryngoscopy to be reliable it is, surely, necessary for the performance of laryngoscopy and grading to be controlled. This has always been assumed to be satisfactory, but grades are decided by the best view obtainable [1, 2], which must depend on the best possible performance of laryngoscopy. Moreover, those responsible for grading have sometimes been numerous—for example, 22 [3] or 36 [2], and it has been observed that laryngoscopy may be performed less than perfectly [2, 4]. This could possibly cause a false incidence of poorer (more difficult) gradings.

Williams, Carli and Cormack [2] stressed the importance of having the head in the Magill position, good relaxation, firm forward traction on the laryngoscope and, if necessary, firm backward pressure on the cricoid. However, some prefer to apply external pressure to the thyroid cartilage, the positioning and direction of the pressure being critical [5]. Cricoid pressure has been suggested as a possible cause of difficulty at laryngoscopy. These authors also are not accurate in stating "in Wilson's study [6], cricoid pressure reduced the frequency of grade 3 from 9% to 1.5%". Wilson and colleagues [6] studied a single puncture at L2-3 level..." and ...catheter was passed about 2-3 cm beyond the tip of needle...". The confusion seems to arise as to the level of anesthesia detected at our institution some 14 days later, when both ascending and descending cord oedema developed which was evident on T2-weighted MR images not included in the report.

In reply to the final point, a spinal angiogram during evaluation of our patient was found not only unnecessary, but would have been dangerous, therefore any suggestions of thrombosis of the artery of Adamkiewicz can only be speculative. Nevertheless, we think it is unlikely even for an arteriopathic patient to develop thrombus whilst undergoing i.v. anticoagulation.

We thank Dr Wildsmith for the opportunity to supplement the information on this rare and unfortunate case.

I. H. TEKKOK
O. CATALTEPE
K. TAHHA
V. BERTAN
Ankara

REFERENCES