overspill, we would recommend regular monitoring of coagulation times so that any spill may be identified quickly and appropriate action taken.

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REFERENCES

NASOPHARYNGEAL AIRWAYS IN INFANTS AFTER PALATAL SURGERY
Sir,—We compliment the authors of the case report advocating the use of a nasopharyngeal airway (NPA) in the postoperative management of cleft palate repair in infants with micrognathia [1] and their concern about the trend to earlier repair. The report emphasizes the danger of sudden postoperative airway obstruction which can occur, not only in these infants, but in other conditions and other age groups. The baby must have had severe laryngeal spasm to produce “asphyxial pulmonary oedema” in such a short time; yet it seems that the cornerstone of management after the second extubation was maintenance of a patent nasal airway using NPA plus CPAP, then NPA alone. The baby’s continued improvement must be attributed to prevention of a further episode of nasal airway closure and collapse of the hypopharynx, rather than directing pressure support to the lower airway by leaving the tracheal tube in situ.

At the Royal Alexandra Hospital for Children we have, for some years, used NPA in virtually all our infant cleft palate surgery. Closure of the cleft palate results in conversion of the hitherto undivided upper airway into naso- and oropharynx, separated by the “new” tissue of the surgical flap. It is not surprising that infants, as oblige nose breathers, may have difficulty coping during emergence from anaesthesia. Digby Leigh and Kester [2] in 1948, noted the problem of “the strange architecture of the upper air passages”, and in 1963 Whalen and Conn [3] advocated the use of the NPA in the postoperative period, and nursing the very difficult airway problems (Kippel–Feil, Pierre–Robin) with the patient in the prone position. Other case reports of early and late upper airways obstruction after cleft palate repair in Pierre–Robin syndrome can be found—not always in the anaesthetic literature [4]—and a perioperative fatality has been reported [5].

Limiting one’s concern to the recognized syndromes risks underestimating the potential problem: reviewing a recent sample of our patients, we note that, of 85 infants, 25% had a named syndrome, 13% had a cleft palate associated with another major congenital anomaly—an “un-named syndrome”—and 62% were isolated clefts.

We consider it unwise to attempt to pass the airway in the recovery room after the problem presents; the risk of damaging the repair itself is too great. The ideal time is at the end of surgery, so that the airway may be guided gently around the posterior margin of the repair and secured so that its tip does not impinge on the supraglottis. The infant is then awakened and the tracheal tube is removed. The NPA is routinely left in place overnight, and may be in situ for long periods of time in such conditions as chomastralia.

Our surgeons commonly ask for NPA in older children having pharyngeal surgery, for the obvious advantages, including gentle suction and a smooth postoperative course. For example, obstructive apnoea is well described in Shprintzen’s Syndrome [6], one of the commoner presentations of velopharyngeal incompetence in older children, and an NPA ensures a patent upper airway well into the postoperative period.

We wholeheartedly support the authors’ general conclusions, but wish to highlight the wider application of NPA in pharyngeal surgery in infants and children.

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REFERENCES

THE IDEAL SPINAL NEEDLE
Sir,—We read with interest the letter by Lyons and Macdonald [1]. Although our experience is limited to only 65 patients, we suggest that the 25-gauge Whitacre needle represents the nearest to an ideal spinal needle for use in the obstetric patient.

From a technical point of view, the needle is easy to handle and gives a clear feel of dural puncture. There is a good flow of CSF down the hub of the needle, with the patient in either the sitting or the left lateral position. In 65 patients we have experienced no failure to find the subarachnoid space; however, there have been two failures of the spinal to reach sufficient height for operation. All patients have been allowed to sit upright immediately after Caesarean section to allow for easier nursing of their babies. All have been fully mobilized less than 24 h after Caesarean section. We have had no incidence to date of post-dural puncture headache (PDPH).

These figures, although small, are encouraging and certainly agree with the less than 1% incidence of PDPH and failure rate of less than 4% suggested by Drs Lyons and Macdonald.

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REFERENCE