TRANSFUSION FOR WAR WOUNDED

Sir,—Eshaya-Chauvin and I published the transfusion requirements of war wounded in your journal [1]. In this article, we stated that the demands of antipersonel mine require 103.2 units of blood per 100 patients; this is more than for patients injured by other conventional weapons. Since the preparation of this article, Korver and I have found that pattern 1 mine injuries (usually requiring surgical amputation) have even greater requirements [2].

The ICRC database for war wounded now contains information on 12895 patients, 2706 of whom were mine injured. Of the mine injured, those who required surgical amputation of a lower limb required 304.6 units per 100 patients. Your readers who are interested in planning a transfusion service for war injured should recognize the implications of buried antipersonnel mines for the volume of blood required.

R. M. COUPLAND
International Committee of the Red Cross
Geneva


THE REINFORCED LARYNGEAL MASK AIRWAY IN PAEDIATRIC RADIOTHERAPY

Sir,—We were interested in the article by Williams and Bailey [1], comparing the use of the reinforced laryngeal mask airway (RLMA) with tracheal intubation in anaesthesia for adenotonsillectomy in adults and children, and the editorial by Wilson, on the laryngeal mask airway in paediatric practice [2]. We have had recent experience using the RLMA size 2 in children younger than 3 yr undergoing anaesthesia for radiotherapy. Difficulties encountered with insertion because of their extreme flexibility made them unpopular in this department, amongst a group of anaesthetists skilled in the insertion of the laryngeal mask airway (LMA) in children.

The development of the LMA has transformed anaesthesia for paediatric radiotherapy when young children require repeated daily anaesthetics in an isolated environment. The LMA, sizes 1 and 2, have been used in more than 2500 anaesthetics given to 145 children over the past 4 years in our radiotherapy department and there have been minimal complications associated with their use [3].

Problems arise when treatments require the child’s head to be placed within a rigid shell, sometimes in the prone position. Flexion of the neck occurs and kinking of the LMA size 2 at the join between tube and mask; it is then put into the mouth to aid correct placement of the RLMA, we position the patient and press up against the hard palate.

To overcome this problem, we were keen to use the reinforced laryngeal mask airway and tracheal intubation for adenotonsillectomy. British Journal of Anaesthesia 1993; 70: 30–33.


Sir,—Thank you for the opportunity to reply to the letter of Drs Moylan and Luce. We did use the insertion technique as described in the manufacturer’s instruction manual [1].

To minimize problems with holding the reinforced laryngeal mask airway (RLMA), we premedicate with an antiallouoguese and ensure that lubricating gel is not placed on the area to be held.

To aid correct placement of the RMLA, we position the patient with the cervical spine flexed and the atlanto-occipital joint extended. The RLMA is held between the thumb and index finger at the join between tube and mask; it is then put into the mouth and pushed up against the hard palate.

In small children, we find that the RLMA can be advanced into the oropharynx and correctly positioned using the index finger alone. The position of the RLMA can be checked and corrected by manual palpation with the index finger. We have no experience with the RLMA in children younger than 3 yr.

Our two failures to insert the RLMA occurred at the beginning of the study period. With experience, the RLMA is almost as easy to insert as the standard LMA. The use of an introducer to stiffen the tube of the RLMA does not help, as it will not prevent lateral rotation of the mask on the tube.

P. J. WILLIAMS
Lewisham Hospital
London

P. M. BAILEY
The Royal National Throat, Nose and Ear Hospital
London


USE OF THE LARYNGEAL MASK AIRWAY IN CHILDREN WITH LARYNGOTRACHEAL PATHOLOGY

Sir,—We read with interest Wilson’s excellent editorial on the laryngeal mask airway (LMA) in paediatric practice [1]. We question, however, his comments about the usefulness of the