participate in medical education and publications. However, her assumption that the patient photographed for this article was unaware of the "consequences of the consent," is erroneous. Informed written consent was obtained; and the published photograph is quite appropriate for the topic of presentation. Any further framing of the face or torso would have resulted in less than optimal illustration of the necessity for correct patient positioning. Any suggestion of impropriety and breach of confidentiality in this case is unwarranted as consent was obtained and editorial and peer review determined the photograph educational. As Slue suggests, the practice of placing a bar across the eyes in a photograph does not ensure patient anonymity, is distracting, and probably should be abandoned in the medical literature.

L.A. Crone MD FRCPC
Department of Anaesthesia
University Hospital
Saskatoon, Saskatchewan
J.M. Davies MSc MD FRCPC
Department of Anaesthesia
Foothills Hospital
University of Calgary
Calgary, Alberta
S.K. Weeks
Department of Anaesthesia
Royal Victoria Hospital
Montreal, Quebec
Edward G. Pavlin MD
Associate Professor of Anesthesiology
University of Washington
Seattle, Washington, USA

Breathing circuit occlusion due to defect in swivel port connector

To the Editor:

Equipment problems and failures are often reported in the anaesthetic literature.^{1,2} We wish to report two cases of occlusion of the breathing circuit secondary to obstruction of the swivel port by foreign bodies. One was operated by the rubber cap which closes the exhalation dome of an ICU ventilating circuit and the second by a black plug of the inflatable mask cushion occluding the swivel port. In the former case, we could not ventilate the patient's lungs after connecting the swivel connector. In the second the lungs could be ventilated but on exhalation airway pressure built up as the black plug worked like a ball valve. All the equipment should be checked prior to anaesthesia. However, these swivel connectors are supposedly disposable. These problems may occur when they are sterilized and reused.

Chidambaram Ananthanarayan MD FRCPC
Gordon Urbach, MD FRCPC
Celeste Tincombe
Richard Smith
Sue Marshall-Hanasyk
University of Toronto
Department of Anaesthesia
Mount Sinai Hospital

REFERENCES

- 1 Cook WP, Gravenstein JS. Breathing circuit occlusion due to a defective paediatric face mask. *Can J Anaesth* 1988; 35: 205-6.
- 2 Wright PJ, Mundy J, Mansfield CJ. Obstruction of armoured tracheal tubes: case report and discussion. *Can J Anaesth* 1988; 35: 195-7.

REPLY

Manufacturers have many concerns as do medical care personnel when devices are re-used. The problem of smaller components being trapped inside any lumen as noted in the letter from Gordon Urbach et al. is a constant potential. When there are bends, especially sharp turns, this may increase the potential of part entrapment. Other concerns for re-use include cleaning and sterilization. The effect on materials when they are processed and re-used may have unexpected effects. We want to emphasize that any critical pathway may result in serious effects if the lumen is plugged, whether it is during preparation for re-use or any time. The cautions stated in the letter are important and we concur with them.

Kenneth E. Little
President
Sims Canada/Concord/Portex

Airway management in C-spine injuries

To the Editor:

We read with interest the manuscript entitled "The adult cervical spine: implications for airway management" by Crosby and Lui (1990; 37: 77-93). We would like to comment on the authors' recommendations, and offer another option for airway management in patients with a known or suspected cervical spine injury.

Crosby and Lui conclude that based on the available data, "... the optimum mode of intubation in a patient with an unstable spine is an awake, fiberoptic bronchoscope-aided intubation ... when indicated." We would like to emphasize that fiberoptic intubation in the acutely trau-