REFERENCES

- 1 Trouwborst A, Haegenow RRP, Jeekel J, Ong GL. Hypervolaemic haemodilution in an anaemic Jehovah's Witness. *Br J Anaesth* 1990; 64: 646-8.
- 2 Gaudiani VA, Mason HDW. Preoperative erythropoietin in Jehovah's Witnesses who require cardiac procedures. *Ann Thorac Surg* 1991; 51: 823-4.
- 3 Lichtenstein A, Eckhart WF, Swanson KJ, Vacanti CA, Zapol WM. Unplanned intraoperative and postoperative hemodilution: oxygen transport and consumption during severe anemia. *Anesthesiology* 1988; 69: 119-22.
- 4 Stone DJ, DiFazio CA. DDAVP to reduce blood loss in Jehovah's Witnesses (Letter). *Anesthesiology* 1988; 69: 1028.
- 5 Bidstrup BP, Underwood SR, Safford RN, Streets EM. Effect of aprotinin (Trasylol) on aorta-coronary bypass graft patency. *J Thorac Cardiovasc Surg* 1993; 105: 147-53.

Lighting the way in emergency airway care

To the Editor:

There are a multitude of factors that contribute to difficult intubation under emergency conditions. One factor is airway soiling, especially with blood. Under normal conditions, illumination of the airway by the direct laryngoscope is enhanced by the reflection of the light off the mucosa. Airway illumination is decreased with airway blood soiling as there is increased absorption of the light cast from the laryngoscope by the dark stained mucosa. This is seen most commonly in patients with facial trauma, severe head injury, multiple trauma and upper gastrointestinal bleeding. Direct laryngoscopy has been popularly referred to as "black hole-oscopy" in this patient population and the most popular and effective adjunct to intubation in this setting has probably been a silent prayer said by the intubating physician.

I have found the lighted stylet to be a very effective aid to intubation in these patients. However, rather than use it to transilluminate the soft tissues of the neck, I have used it in conjunction with a direct laryngoscope. I mount the endotracheal tube on the lighted stylet and then perform direct laryngoscopy. The use of the lighted stylet allows for increased airway illumination and also allows for a focused beam of light to be directed at the targeted tissues. Visualization of the airway is much enhanced. I have used this technique myself for the last three years in the patients cited above and have commended it to others. I have been sufficiently impressed

by their positive response to its application to feel a wider recommendation is perhaps in order.

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Laryngeal mask airway for edentulous patients

To the Editor:

Face mask ventilation of the edentulous patient is often difficult because of the inadequate fitting of the standard mask to the face.¹ It is common practice for one person to hold the mask with both hands over the patient's face while a second person ventilates the lungs by squeezing the bag.² The editorial of Dr. Fisher *et al.* suggests that the laryngeal mask airway (LMA) provides a better alternative to the standard face mask if the facial contours of the patient are not suited to the standard mask.³ The LMA can therefore be utilized in the edentulous patient to circumvent the problem of face fitting and, when properly placed, the laryngeal opening will be totally within the rim of the mask.⁴

We have tried the LMA for ventilation of the anaesthetized edentulous patients. Following preoxygenation of the awake patient using a standard face mask, anaesthesia was induced. The LMA (size 3 or 4) was placed in position and its cuff inflated. The LMA was then connected to the anaesthesia circuit. The absence of teeth facilitated the insertion of the LMA. Also, there was no need for a bite block or an oral airway for protecting the LMA from damage by the patient's teeth. The LMA proved to be superior to the standard face mask/oropharyngeal airway system for maintaining a better seal in the edentulous patient. The technique can be used to ventilate the lungs of the anaesthetized and paralysed edentulous patient prior to tracheal intubation. It can also facilitate maintenance of anaesthesia whenever tracheal intubation is not indicated during surgery, while permitting the anaesthetist's hands to be free to perform other tasks such as drug administration or record-keeping.

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