ed finding was that the enhanced output when using 100% oxygen was greater than the 15% increment described by the manufacturer.²

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FIGURE Vaporizer output (mean, range) stationary and in motion, for FGF 4, 6, and 8 L·min⁻¹.

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Alternative approach to airway management in Nager's syndrome

We read Przybylo *et al.*'s report of retrograde intubation of a child with Nager's syndrome with interest,¹ as we recently managed a similar child with an alternative technique.²

A two-year old, 12.5 kg, uncooperative boy with Nager's syndrome³ presented for tracheostomy revision. Tracheostomy had been performed at birth but after its inadvertent removal one week previously, the child had increasing upper airway obstruction. Closure of the tracheostomy and inability to traverse the stoma fibreoptically was confirmed.

After premedication with midazolam 6 mg, and atropine 0.15 mg *iv*, anaesthesia was induced with sevoflurane by mask and maintained with manual assistance and a size 2 oral airway before a size 2 LMA was easily inserted, followed by blind passage of a size 3.5

endotracheal tube through the LMA at first attempt. Tracheal placement was confirmed with auscultation, end-tidal CO₂ and fibreoptic visualization.

Although rare, children with Nager's syndrome present considerable airway problems. We report our experience with a trans-LMA technique² facilitating expeditious control of the airway (induction to intubation time of four minutes).

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- 2 Rabb MF, Minkowitz HS, Hagberg CA. Blind intubation through the laryngeal mask airway for management of the difficult airway in infants. *Anesthesiology* 1996; 84: 1510-1.
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REPLY

Pivalizza *et al.* report successful airway management of a child with Nager's syndrome using blind intubation via an LMA placed while the child was ventilating spontaneously. As stated in our original case report,¹ there are several techniques that can be used for airway management in children that present with the potential combination of both difficult intubation and difficult mask ventilation. The critical point that we would reemphasize is that it is prudent to take advantage of the patient's natural airway and ability to breathe spontaneously when choosing which technique is best to secure the airway.

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