resuscitation – results of a multicentre trial. Anaesthesia 1994; 49: 3–7.
5 *Kokkinis K.* The use of the laryngeal mask airway in CPR. Resuscitation 1994; 27: 9–12.
6 *Paterson SJ, Byrne PJ, Molesky MG, Seal RF, Finucane BT.* Neonatal resuscitation using the laryngeal mask airway. Anesthesiology 1994; 80: 1248–53.
7 *Greene MK, Roden R, Hinchley G.* The laryngeal mask airway. Two cases of prehospital trauma care. Anaesthesia 1992; 47: 688–9.
8 *Lee JJ, Yan K, Barcroft J.* LMA and respiratory arrest after anterior cervical fusion (Letter). Can J Anaesth 1993; 40: 395–6.
9 *Brimacombe J.* The laryngeal mask airway for emergency airway management in the special care baby unit (Letter). Br J Hosp Med (In Press).
10 *Fisher JA, Ananthanarayan C, Edelist G.* Role of the laryngeal mask in airway management (Editorial). Can J Anaesth 1992; 39: 1–3.

REPLY

I have no major difference of opinion with those stated in Brimacombe's letter although I would like to offer some additional observations. Anecdotal reports generally apply only to the situation they describe and may not be easily applied to the general population. Studies of the use of the laryngeal mask airway (LMA) by personnel unskilled in airway management have been performed in healthy, anaesthetized and paralyzed patients.[1–3] *These findings may not be applicable to patients in the resuscitation setting. A larger series evaluating airway management techniques by unskilled personnel during resuscitation use, as their end points, the time required to establish an airway and the effectiveness of pulmonary ventilation. The laryngeal mask airway offers clear advantages over conventional methods of pulmonary ventilation such as bag valve mask devices or mouth-to-mouth respiration when these end points are studied.*[4] *Unfortunately, there have been no controlled clinical trials comparing the LMA with other techniques of airway management in which survival, quality of survival or aspiration were used as study end points. Paterson et al. reported on the use of the LMA by trained anaesthetists and neonatologists during neonatal resuscitation. Similar to previous studies, they found a high success rate of LMA placement and airway management in their study population. However, this group cautions that their results should not be extended outside the population studied.*[5]

I agree with Dr. Brimacombe's comments that properly controlled field trials are necessary before the LMA can be recommended for general use in emergency situations.

J.H. Devitt MD FRCPC
Toronto, Ontario

REFERENCES
1 *Alexander R, Hodgson P, Lomax D, Bullen C.* A comparison of the laryngeal mask airway and Guedel airway, bag and facemask for manual ventilation following formal training. Anaesthesia 1993; 48: 231–4.
2 *Martin PD, Cyna AM, Hunter WAH, Henry J, Ramayya GP.* Training nursing staff in airway management for resuscitation: a clinical comparison of the face mask and laryngeal mask. Anaesthesia 1993; 48: 33–7.
3 *Pennant JH, Walker MB.* Comparison of the endotracheal tube and laryngeal mask in airway management by paramedical personnel. Anesth Analg 1992; 74: 531–4.
4 *Stone BJ, Leach AB, Alexander CA, Ruffer DR, MacBeth, et al.* The uses of the laryngeal mask airway by nurses during cardiopulmonary resuscitation: results of a multicentre trial. Anaesthesia 1994; 49: 3–7.
5 *Paterson SJ, Byrne PJ, Molesky MG, Seal RF, Finucane BT.* Neonatal resuscitation using the laryngeal mask airway. Anesthesiology 1994; 80: 1248–53.

Laryngoscope light intensity

To the Editor:

I read with interest the discussion on light intensities produced by fibreoptic and "bulb-on-blade" types of laryngoscopes.[1] My colleagues and I previously measured a similar difference in light intensity to that described by Tousignant and Tessler, also using a camera light meter.[2] Our laryngoscopes used the same type of batteries and bulb, irrespective of whether they were of fibreoptic or bulb-on-blade design. Thus the cause for this difference in light output had to be distal to the bulb. One explanation considered was that the optical fibres broke over time; indeed, viewing the light coming from the optical fibres frequently showed crescentic dark areas. However, these dark areas could be lit by moving the blade in its handle mount suggesting not that the fibres were broken, but that they were receiving no light input. It is unlikely that the fibres break as they are mounted in a rigid metal tube – flexible endoscope optical fibres survive far more motion before failing. Further investigation of our findings suggested that the light is lost between the bulb and the entry point of light into the fibre-optic bundle in the blade. Light not focused directly onto the optical fibre bundle is absorbed into the base of the laryngoscope blade or shines out of the crack between blade and handle. This effect is enhanced by any looseness or gap between the handle and blade. In the "bulb-on-blade" design, this light, although not necessarily projected onto the larynx directly, would reflect around the oro- and hypo-pharynx and contribute to the identification of key landmarks visualized during laryngoscopy, resulting in greater ease of use. Manufacturers need to address this issue, as many hospitals are now moving