phy. MRI is very sensitive in detecting CSF accumulation and pseudomeningocele.

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Maxillary jewelry in a parturient: a new cause for concern

To the Editor:
A new fashion of self-expression through body piercing in unconventional sites among young adults (including pregnant women) appears to continue to increase in our society. We previously described the anesthetic implications of oral (tongue piercing),[1] and nasal (alar piercing),[2] jewelry in parturients requiring anesthesia in the peripartum period, and made a recommendation that oral/nasal jewelry should be removed prior to the administration of anesthesia (of any kind). However, we recently administered an uneventful epidural anesthesia to a 22-yr-old parturient with a non-reassuring fetal heart tracing for forceps assisted vaginal delivery. The patient had a piece of jewelry attached to her maxillary gumline with through and through fixation (Figure). Removal of the maxillary jewelry would have required special tools. We elected to *not* try and remove the maxillary jewelry because of the urgent nature of the case. We would welcome comments from colleagues from other institutions on their guidelines for the management of labour analgesia in parturients presenting with oral/nasal jewelry *in situ*.

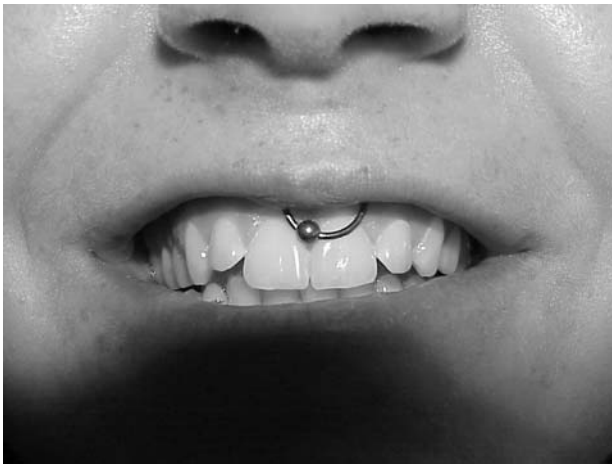

FIGURE Gingival jewelry (anterior view).

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Remifentanil pretreatment for propofol injection pain in children

To the Editor:
Pain on propofol injection is a recognized problem in the pediatric population and several methods have been studied to reduce its incidence and severity.[1,2] We designed this study to assess the effectiveness of remifentanil in minimizing pain on injection of propofol in children. After Ethics Committee approval and written parental informed consent, healthy children ASA I or II status aged 5 to 12 yr scheduled for otolaryngological surgery were included in the study. Children with a past history of an adverse response to propofol, who refused *iv* induction, in whom we failed to insert an *iv* cannula on the back of the hand or who had cognitive or behavioural disorders were excluded from the study. When the patient arrived in the anes-

thetic room, a venipuncture was performed using a 22-gauge catheter without local anesthetic skin infiltration. This was flushed with 2 mL of normal saline. Children in Group I received remifentanil 0.25 $\mu g \cdot kg^{-1}$ (diluted with normal saline to 5 mL) over 30 sec followed 60 sec later by propofol. Group II received remifentanil 0.5 $\mu g \cdot kg^{-1}$ (diluted with normal saline to 5 mL) over 30 sec followed 60 sec later by propofol. The propofol (3 $mg \cdot kg^{-1}$) was injected over 20 sec and a blinded observer noted propofol pain on the four-point behavioural pain scale proposed by Cameron e*t al.*:[3] 0 = no pain; 1 = mild pain (grimace); 2 = moderate pain (grimace + cry); and 3 = severe pain (cry + withdrawl). The injection was performed manually by one of the investigators who gauged the speed of injection from the wall-mounted clock. The incidence of pain was 60% in Group I compared with 23.5% in Group II ($P < 0.001$). Moderate and severe pain occurred in 22% and 14% respectively of patients in Group I, compared to 11.7% and 1.9% in Group II ($P < 0.001$). These results indicate that remifentanil pretreatment (0.5 $\mu g \cdot kg^{-1}$) 60 sec before propofol administration significantly reduces pain associated with propofol injection in children compared to remifentanil 0.25 $\mu g \cdot kg^{-1}$. The site of action of remifentanil in reducing pain may be either central or peripheral. The dose we used is low and is lower than the dose which one would choose if one wanted a central analgesic effect. Opioid receptors are present at peripheral sensory nerve terminals in humans. Remifentanil has a selective agonist action at μ opioid receptors.[4] It is possible that the reduction in injection pain was the result of a peripheral action.

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Awake intubation using the GlideScope® video laryngoscope: initial experience in four cases

To the Editor:

The GlideScope® video laryngoscope (GVL; Saturn Biomedical Systems, Burnaby, BC, Canada) is a novel system for tracheal intubation that utilizes a video camera embedded into a plastic laryngoscope blade.[1,2] The blade is 18 mm at its maximum width, and bends 60° at the mid-line. This configuration provides a view superior to that obtained with a conventional laryngoscope. Experience using the GVL in anesthetized patients has been excellent, but limited;[1,2] experience in awake patients is even more limited. The purpose of this note is to describe use of the GVL in four cases of awake intubation.

In the first two cases the initial plan was to use fibreoptic methods, but the equipment was unavailable, so the GVL was used instead. Later, having had a prior favourable experience, the GVL was used electively, even though a difficult airway cart was available. In three cases the indication for awake intubation was morbid obesity. The remaining patient had a limited mouth opening (2.5 cm) that would have made ordinary intubation difficult.

Following sedation with midazolam, the airway was anesthetized with gargled and atomized 4% lidocaine; superior laryngeal and transtracheal blocks were not employed. Once a good view of the glottis was obtained, additional lidocaine was administered under direct vision, using a MADgic® atomizer (Wolfe Tory Medical, Salt Lake City, UT, USA). A malleable stylet bent at 90° was used. In all cases a good view of the glottis was obtained and the endotracheal tube (ETT) was passed without difficulty. In the patient with limited mouth opening the GVL was just able to be introduced.

There are several advantages of using the GVL for awake intubation. First, the view is excellent. Second, the method is less affected by secretions or blood as compared to fibreoptic intubation. Third, everyone can view the intubation, while this is the case only for video bronchoscopes. Fourth, the intubation can be recorded using a regular camcorder. Fifth, there are no restrictions on the type of ETT that can be placed, while this is not the case for fibreoptic methods. Sixth, the GVL is more rugged than a bronchoscope, and is