Patients

Fig. 1. Histogram of OLT recipients and number of units of blood transfused intraoperatively, and a superimposed 72-h perioperative mortality curve.

intraoperative mortality was only 0.5%; in contrast, in those who received 61-80 U and more than 80 U, mortality was 70% and 86%, respectively. The LD50 for blood administration was approximately 58 U of blood.

Our analysis does not address the precise factors that contribute to early postoperative mortality after OLT. Although there are certainly a multitude of factors (preoperative, intraoperative, and postoperative) that have an effect on survival, our data suggest that intraoperative blood usage during OLT may reflect the sum total of donor and recipient factors that may contribute to patient mortality.

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To the Editor—A 17-month-old 9.5-kg boy with Pierre Robin syndrome presented for repair of a cleft palate. Anesthesia was induced with sevoflurane in oxygen, and ventilation was maintained with the help of oropharyngeal airway. However, the vocal cords could not be observed during direct laryngoscopy, and hence a #2 laryngeal mask airway was inserted. After testing the ability to ventilate the patient with moderate positive pressure via the laryngeal mask airway, 1 mg of vecuronium was administered intravenously. A fiberoptic bronchoscope (FOB; Olympus BF 3C-30, Olympus, Tokyo, Japan) was then passed into the pharynx through a self-sealing port in the elbow connector. A J-tipped guidewire was passed through the suction port of the FOB into the trachea under direct vision, and the FOB was then removed. A tube exchanger (Cook Airway Exchange Catheter with Rapi-Fit Adapter, Size 8 French, Cook Critical Care, Bloomington, IN) was passed over the guidewire into the trachea. The guidewire and laryngeal mask airway were then removed, and a 4.0-mm-ID endotracheal tube was passed over the tube exchanger into the trachea. SpO2 was maintained between 99% and 100% during the procedure.

The use of FOBS to assist in the passage of small pediatric endotracheal tubes typically requires a small pediatric FOB that can be passed through the tube. Such FOBS are not available in all hospitals. Our intubation technique is likely to be valuable when a small pediatric FOB is not available. It also facilitates removal of the laryngeal mask airway. Similar techniques, such as passing the endotracheal tube directly over the guidewire1 or ureteral dilator,2 have been reported. However, a flexible guidewire seems to be an unreliable guide to the endotracheal tube. Moreover, with these techniques, it is difficult to oxygenate the patient while inserting the endotracheal tube. The use of a commercial tube exchanger, which can be used with a jet injector, can overcome this difficulty.

Intubation of a Child with a Difficult Airway Using a Laryngeal Mask Airway and a Guidewire and Jet Stylet

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