CORRESPONDENCE

anesthetic within the subarachnoid space may be associated with this neurologic symptom. Our results indicate that a subsequent injection at the same interspace after a failed spinal anesthesia has the risk of neurologic injury. A subsequent injection should be attempted at a higher interspace to avoid reinforcing the same restricted distribution. In addition, a combined dose that exceeds the standard recommendation for single-injection spinal anesthesia still has risk of injury, even if a different interspace is used, and hence other modifications, such as altering patient position, using an anesthetic with a different baricity, or straightening the lumbosacral curvature, should be considered.1

Yoshihiro Hirabayashi, M.D.
Lecturer
yhira@jichi.ac.jp

Ruriko Konishi, M.D.
Instructor

Anesthesiology
1998; 89:1295
© 1998 American Society of Anesthesiologists, Inc.
Lippincott Williams & Wilkins

Reiju Shimizu, M.D.
Professor
Department of Anesthesiology
Jichi Medical School
Tochigi, Japan

References

2. Aboulieh E. How to proceed following a “failed spinal.” Anesthesiology 1992;76:476

(Accepted for publication June 11, 1998)

Laryngeal Mask Airway Fitted over a Tracheotomy Orifice: A Mean to Ventilate a Tracheotomized Patient during Induction of Anesthesia

To the Editor—It is occasionally difficult to ventilate a tracheotomized patient. In such a patient, controlled ventilation through a face mask is difficult. Some patients can easily tolerate topical anesthesia and awake insertion of an endotracheal tube through a tracheotomy orifice, followed by the anesthesia. However, for those who cannot, deep anesthesia and muscle relaxation before tube placement may be preferable.

In such a situation, ventilation using a small laryngeal mask fitted over a stoma has proven to be a reasonable solution (fig. 1). With this method, we can easily ventilate a patient and control the depth of anesthesia.

Ventilation via a tracheostomy using a pediatric mask over the stoma has been reported previously.1 Unfortunately, in some cases, it is difficult to fit a pediatric mask because of a hollow between clavicles, the sternum, and sternomediastinaloid muscles. In such cases, the use of a small laryngeal mask airway may be of value.

Yasuhiro Morita, M.D.
Resident

Makoto Takenoshita, M.D.
Assistant Professor
Department of Anesthesiology
Osaka University Medical School
Osaka, Japan
makoto@anes.med.osaka-u.ac.jp

Fig. 1. Laryngeal mask fitted over a tracheotomy orifice.

Reference


(Accepted for publication June 11, 1998)

Anesthesiology, V 89, No 5, Nov 1998