affercnt sensory impulses arising from areas of increased tone and sensitivity. However, diffusion of botulinum toxin into peripherally afferent muscles can cause dysphagia and serious respiratory compromise as a possible side effect, and so knowledge of the toxin's effects and proper placement of the toxin are imperative.  

We have started a clinical research study assessing the efficacy of botulinum A toxin in the treatment of chronic disabling myofascial pain.

Martin A. Acquaro, M.D., D.M.D., F.A.C.P.M.  
Clinical Instructor, Anaesthesiology  
Harvard Medical School  
Associate Director of Education  
Director of Pain Management Unit  
Department of Anaesthesiology  
Massachusetts Eye and Ear Infirmary

Gary E. Borodic, M.D.  
Assistant Professor, Ophthalmology  
Harvard Medical School  
Department of Ophthalmology  
Massachusetts Eye and Ear Infirmary  
243 Charles Street  
Boston, Massachusetts 02114

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The Laryngeal Mask Airway: Its Uses in Anesthesiology

To the Editor:—We read with interest the informative and comprehensive review by Pennant and White on the laryngeal mask airway (LMA) in anaesthesiology.  

A number of points, however, merit further discussion. We present some additional information that may be helpful to the practitioner.

First, there is considerable evidence that the LMA does have a role in the management of the difficult airway, a view supported by the American Society of Anaesthesiologists Task Force on Management of the Difficult Airway.  

There is, however, no evidence for an inverse relationship between difficulty of tracheal intubation and ease of insertion of the LMA, only evidence that LMA insertion is not compromised in patients with anticipated intubation difficulty.  

Pennant and White state that an inability to extend the neck is a contraindication to use of the LMA. Two recent studies, however, have demonstrated that insertion can easily be achieved with the neck in the neutral position or in a hard collar, suggesting that the LMA may have a role in the fastest patient with cervical spine instability.

Second, although it has been shown that in 30% of patients (only 56% with cricoid pressure applied) the trachea can be blindly intubated via the LMA, this probably represents the best possible result. A recent report has shown much lower success rates despite good LMA position. In the emergency situation, therefore, it may be safer to continue ventilation via the LMA while maintaining cricoid pressure rather than attempt blind intubation. A proposed algorithm for the use of the LMA after failed intubation in the patient with a full stomach has recently been published.

J. Brimaconbe, M.B., Ch.B., F.R.C.A.  
Senior Lecturer
A. Berry, M.B., Ch.B., F.R.C.A.  
Research Registrar
Department of Anaesthesia  
Cairns Base Hospital  
Cairns  
Australia 4870
C. Verghese, M.B., Ch.B., F.R.C.A.  
Consultant  
Department of Intensive Care and Anaesthesia  
Royal Berkshire Hospital  
London Rd  
Reading  
Berkshire RG1 5AN  
United Kingdom

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In Reply—We question Brimacombe and colleagues’ suggestion that there is “considerable evidence” that the laryngeal mask airway (LMA) has a role in emergency airway management. Although it has been suggested that the LMA is a useful device for managing emergency airway problems, the evidence is to date purely anecdotal. We are currently performing a controlled study of the LMA in managing the difficult airway in the field; however, until the results of this study and other similar research are available, the suitability of the LMA for the emergency airway situation can be considered only speculative. Furthermore, adequately controlled studies in this area are exceedingly difficult to perform because of the infrequency and unpredictability with which the difficult airway is encountered.

Since we submitted our review article,1 nearly 150 articles on the LMA have appeared in the anesthesiology literature. At the time of our submission, neck immobility was regarded as a contraindication to the use of the LMA.2 We agree that recent work suggests that the inability to extend the head is not an absolute contraindication to the use of the LMA.3 In fact, the LMA may be a very useful technique for obtaining a patient airway in these cases. However, there will continue to be situations in which the LMA cannot secure these airways (e.g., it may prove impossible to advance the LMA cuff into the hypopharynx in some patients with severe cervical spine pathology).4 and alternative techniques and equipment must be available.

The ability to perform a blind intubation through the LMA depends on the device used (e.g., gum elastic bougie,3 tracheal tube,6 or Cook airway exchange catheter)7 and the degree of muscle relaxation. The 30% success rate reported by Brimacombe and Berry7 using the Cook airway exchange catheter suggests that this device is not suitable because of its rigidity and the difficulty in angulating its distal tip. In an emergency situation, it may indeed be safer to continue positive-pressure ventilation via the LMA (while maintaining cricoideal pressure) rather than attempt to perform a blind intubation. Given the greater than 84% chance of success with a bougie or tracheal tube, a quick attempt at blind intubation is not unreasonable. However, if spontaneous respiration is anticipated to resume rapidly, it may be safer to allow the patient to awaken with the LMA in place.

We agree that the LMA is an extremely useful airway device for both routine (elective) and emergency cases. However, carefully controlled clinical trials, rather than additional anecdotal reports, are needed.

John H. Pennant, M.A., M.B., B.S., F.R.C.A.
Assistant Professor of Anesthesiology

Paul F. White, Ph.D., M.D.
Professor of Anesthesiology

Department of Anesthesiology
The University of Texas Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, Texas 75235-8894

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