reinforced endotracheal tube. Two 3-0 silk sutures are passed through several rings of the tube 180° apart; multiple knots are tied to secure these sutures (fig. 1). These sutures and knots are then wrapped in Microfoam® tape to prevent subsequent pressure necrosis. Maxisgel® skin adhesive is applied to the cheeks; the wrapped sutures are then placed on the sticky skin. Finally, two small pieces of Tegaderm® are applied over the skin and foam-wrapped sutures (fig. 2). The technique we describe avoids the need for adhesive tape around the endotracheal tube itself. This leaves the tube less susceptible to wetting by blood, secretions, or skin preparation solutions. We have used this technique successfully for many procedures over the last 5 y without complications.

**Babette Horn, M.D.**
Assistant Professor of Clinical Anesthesia and Pediatrics

**George W. Stevenson, M.D.**
Associate Professor of Clinical Anesthesia

Department of Anesthesiology
Children's Memorial Hospital
Northwestern University Medical School
2300 Children's Plaza
Chicago, Illinois 60614

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**Use of a Dental Mirror as an Aid to Tracheal Intubation in an Infant**

To the Editor:—A 2½-month-old full-term infant was scheduled for elective bilateral hernia repair under general anesthesia. Physical examination revealed a vigorous 3.9-kg child with a complete cleft palate and slightly receding chin.

Anesthesia was induced using nitrous oxide, oxygen, and halothane via mask. An intravenous catheter was inserted and 0.1 mg atropine followed by 10 mg succinylcholine was administered intravenously. Intubation was attempted using a #1 Miller laryngoscope blade multiple times without success. Only the tip of the epiglottis was visualized during laryngoscopy. Spontaneous ventilation with the patient breathing halothane and oxygen was reestablished. Hemoglobin oxygen saturation of 100% and end tidal carbon dioxide around 38 mmHg were maintained during the procedure. With the head in full extension, a #1 Macintosh laryngoscope blade was used to retract the tongue. A #3 short handle dental mirror (Storz Instrument Company, Manchester, CT) was defogged and placed with the right hand in the oropharynx to visualize the larynx. The handle of the mirror was moved to the left side and held along with the laryngoscope by the left hand, keeping the image of the larynx in the mirror. The left thumb was used to hold the handle of the mirror, pressing against the oropharynx to keep it steady (fig. 1A). A 3-mm endotracheal tube with stylet appropriately curved, coinciding with the curve of the Macintosh laryngoscope blade, was positioned in front of the mirror.

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**Fig. 1.** (A) Dental mirror and the laryngoscope held in left hand, which exposes the larynx in the mirror. (B) The endotracheal tube is advanced into the larynx looking into the dental mirror.
This technique is very simple and does not need expensive instruments such as a pediatric flexible fiberoptic. Insufflation with oxygen and halothane can be instituted easily to prevent the patient from responding during the procedure. A similar technique can be adapted to tracheal intubation in adult patients with anterior larynx or in conditions where the patient's neck cannot be manipulated.

A Storz #3 dental mirror was used in this case (fig. 2). The Storz dental mirror can be custom-made to different angles to suit different airway anatomy. A Labordette laryngoscopy speculum, Siker laryngoscope blade, Robert Miller indirect laryngoscope, Huffman prism, and Bellhouse angulated laryngoscope work on the same principle to visualize the larynx indirectly in adult patients.

In summary, we are reporting an inexpensive, readily available, easy-to-learn technique as an alternative to direct laryngoscopy in difficult airway situations in children to intubate the trachea.

Vijayakalshmi U. Patil, M.D.
Associate Professor of Anesthesiology
Andrew M. Sopchak, M.D.
Resident in Anesthesiology
P. Sebastian Thomas, M.D.
Professor of Anesthesiology
SUNY Health Science Center at Syracuse
Department of Anesthesiology
750 East Adams Street
Syracuse, New York 13210

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Increased Intracranial Pressure in Head Trauma Patients Given Fentanyl or Sufentanil

To the Editor:—We read with interest the recent article by Sperry et al., describing a modest increase in intracranial pressure (ICP) in head trauma patients given fentanyl or sufentanil. They administered 0.6 μg/kg sufentanil or 5 μg/kg fentanyl in a randomized, double-blind fashion and observed increases in ICP of 7.7 and 6.1 mmHg after fentanyl and sufentanil, respectively. In their discussion, they appropriately point out the importance of the 9–10 mmHg decrement in mean arterial blood pressure (MAP) or neuroexcitation to their observations. We would like to elaborate on these speculations.

The decrease in MAP, besides contributing to ischemia, may in fact have been the primary cause of a reflex increase in ICP. Rosner et al. have demonstrated how ICP can increase in the subset of