Drs. Lee et al. rather well. Alternate methods of zygo-
matic stabilization include open reduction and fix-
ation at the fracture sites; antral support with gauze
packing or Foley catheter balloon inflation; and extra-
skeletal pin fixation. Since the Kirschner wire tech-
nique is blind, the course of advancement of the wire
is not certain. In addition to skewering a nasal endo-
tracheal tube, such wires may come to rest between
the pilot tube and the endotracheal tube and may be
extended laterally to impede mandibular motion by
contact with the coronoid process. One additional haz-
ard in this dangerous technique with a threaded wire
is wrapping of a peripheral branch of the facial nerve
around the Kirschner wire. There is a potential for
avulsion far proximal to the site of entry of the Kirsch-
ner wire. A Kirschner wire might accidentally be di-
rected or curve toward an orbit, resulting in dire con-
sequences. In summary, the hazards of this technique
far outweigh the speed it allows. The anesthesiologist
should be alerted to these potential problems.

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Heated Humidification for Infants during Anesthesia

To the Editor: — We commend Bennett et al.1 for the
excellent results achieved in maintaining body tempera-
ture in neonates during anesthesia and opera-
tion by using ambient temperature, Vi-drape®,
a warming mattress, and warming of blood. Anesthetic
gases were not heated, and it is unclear whether they
were humidified. We are concerned that this report
implies that heated humidification of anesthetic gases
delivered through a T-piece circuit is not necessary.
We evaluated the benefits of a new heated humidifier* in
29 infants and small children undergoing anes-
thesthesia and operation using a Jackson Rees® modifica-
tion of the Ayre’s T-piece.2 An ambient tempera-
ture of 23.9 °C, warming blanket at 37.5 °C, and any
blood administered warmed to 37.5 °C were used in
all patients. The control group of 13 infants was man-
aged without heating or humidification of the an-
esthetic gases. In the control group, 11 of 13 patients
showed decreases in body temperature averaging
1.72 °F. In the study group of 16 patients in which
the heated humidifier was used, only four of 16 pa-
patients showed decreases in body temperature, and
the group as a whole averaged a 0.71 °F gain. Heated
humidification is not only helpful in maintaining body
temperature, but prevents damage to the ciliated
epithelium of the tracheobronchial tree caused by
dry anesthetic gases.3

Bennett et al.1 also concluded that complaints from
the operating room personnel of the high ambient
temperatures were a small price to pay for minimiz-
ing the deleterious effects of hypothermia in the

newborn. However, when using ambient temperatures
above 26 °C we have experienced difficulty from in-
creased sweating of operating room personnel caus-
ing prolongation of the surgical procedure and pos-
sible contamination of the surgical site. Although we
agree that ambient operating room temperature is the
most important factor in maintaining body tempera-
ture in infants and children, we strongly recom-
mand that heated humidification be used as an adjunct
when employing a T-piece circuit.

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*Harlake Series 328 Respiratory Humidifier.

(The Editor regrets the delay in publication, which resulted from a clerical oversight.)