

CORRESPONDENCE

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In Reply:—Mayhew objects to our use of a muscle relaxant to facilitate tracheal intubation in an infant with severe micrognathia. Maintenance of spontaneous ventilation is an important *consideration* but not the “first tenet” of airway management when one anticipates difficulty with tracheal intubation. Spontaneous ventilation during induction of anesthesia appears to be preferable for patients with laryngeal disease or with mediastinal tumors. It is important to distinguish between those patients whose anatomy will make tracheal intubation using direct laryngoscopy difficult from those whose anatomy will make spontaneous or controlled ventilation with an anesthesia bag and mask difficult.

Patients with severe micrognathia have a normal larynx with an abnormal access to the larynx. It may prove difficult to sustain adequate ventilation once these patients are anesthetized since the usual maneuvers that support the mandible are less effective and occasionally ineffective. However, if the patient can be anesthetized breathing spontaneously, and if subsequently ventilation can be assisted and then controlled, then paralysis is not contraindicated. In many ways paralysis is beneficial since bradycardia, hypotension, la-

ryngospasm, airway trauma, and vomiting with resultant aspiration can be avoided.

No single approach to patients with abnormal airway anatomy will be useful every time. The lighted stylet is a tool that allows the anesthesiologist skilled in its use another option. The lighted stylet can be used for oral or nasal tracheal intubation, and our report extends the usefulness of the technique to patients as small as newborn infants. Practice with the technique in patients with normal airway anatomy takes no additional time compared to direct laryngoscopy and allows the clinician to develop proficiency.

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Is It Really Free?

To the Editor:—As members of the American Society of Anesthesiologists (ASA) and participants in that society's recent 1992 convention, we were surprised and concerned over the obvious commercialism and resultant cost of the trade exhibits. These costs, although borne by the sponsoring companies, are inevitably passed on to the patient and contribute to the overall cost of health care. One trade exhibitor informed us that his company's display expenditure cost more than \$500,000. The cumulative cost of hundreds of elaborate exhibits including amusement park rides, countless giveaways, and corporate-sponsored gala dinners must reach astronomic figures. Just as the American Medical Association has issued statements and recommendations against accepting “perks,” we wonder whether the ASA should consider limitations on elaborate exhibits, giveaways, and corporate-sponsored events at its meetings. Certainly the dissemination of educational materials and information is desirable. This

can be accomplished in less elaborate ways not requiring large expenditures. The concept that our practice patterns and therapeutic decisions can be influenced by entertainment and gifts is insulting and should not be perpetuated.

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In Reply:—Morell, Foreman, and Royster raise the issue of the cost to exhibitors at the American Society of Anesthesiologists (ASA) annual meeting and ask the question, “Is it really free?”

The answer is both yes and no. The ASA does not require its members to pay a registration fee at its annual meeting, which is the second largest source of income to the ASA—second only to member dues