severe anaphylactoid reaction during open heart surgery probably caused by protamine. The findings of an elevated tryptase and positive protamine skin tests remain inadequate to answer questions concerning the mechanism of this severe reaction.

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In Reply:—As Kindler and Bircher correctly point out, immunoglobulin E and immunoglobulin G antibodies to protamine were not measured, and, therefore, the precise mechanism underlying our observations remains uncertain. Although I did not have control subjects, I do not think the protamine with concentrations between 10 and 100 μg/ml used in our report induced irritative skin responses. Weiler *et al.*[1] reported that out of 85 patients who were skin tested with 0.001–0.1 mg/ml protamine, only 3 were positive, and the protamine concentration at which these 3 patients showed positive reactions was 0.1 mg/ml.

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Fiberoptic Tracheal Intubation Using a Nipple Guide

To the Editor:—Fiberoptic tracheal intubation of the infant may be assisted *via* a laryngeal mask airway (LMA), a standard mask, or a ventilating mask.[1] Of these devices, only the LMA acts as an oropharyngeal-laryngeal conduit, through which a flexible fiberoptic bronchoscope may be placed directly above the vocal cords. Unfortunately, the LMA is poorly tolerated by the awake infant. We describe an alternate device that facilitated fiberoptic bronchoscopic tracheal intubation of an infant with an unstable cervical spine who could not be safely anesthetized before intubation.

A 7-month-old expremature infant with a history of bronchopulmonary dysplasia, apnea and bradycardia of prematurity, and chronic respiratory failure that required prolonged intubation was admitted with rapidly progressive upper extremity weakness. A magnetic resonance imaging (MRI) examination was indicated to rule out a space-occupying lesion that involved the spinal cord. The combination of the patient's medical history and his remote position while in the MRI scanner necessitated tracheal intubation with controlled ventilation. Because of his progressive paralysis, we were compelled to assume that his cervical spine was unstable, and that direct laryngoscopy might result in permanent neurologic damage. In summary, we were confronted with a 7-month-old boy with an unstable cervical spine who could not sustain more than mild sedation for the fiberoptic placement of an endotracheal tube.

Fiberoptic bronchoscopy was performed in the operating room