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In Reply:—The publication of several letters to the editor concerning management of the bearded airway occurred concurrent to the formulation of our correspondence[1] and were regretfully excluded from the discussion and references. This flurry of furry correspondence in the journal *Anaesthesia* highlights the ubiquity of the problem, and also the range of solutions, depending on the resources that are available.[2–7]

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Aseptic Meningitis after Spinal Anesthesia in an Infant

To the Editor:—We read with interest the report by Easley *et al.*[1] of aseptic meningitis after spinal anesthesia in an infant. Although the report is a poignant reminder that this complication is a risk when performing spinal anesthesia in any patient, adult or neonate, we have several concerns. First, the differential diagnosis between viral meningitis and aseptic meningitis is, at best, difficult to make. Based on the authors description of the cerebrospinal fluid findings, diagnosis does not rule out viral meningitis.[2] Second, in the concluding paragraph, the authors state that they suspected aseptic meningitis, but could not prove a causal relation.[1] As illustrated in a recent report of two infants who were diagnosed with meningitis—one after and one immediately before placement of a spinal anesthetic—the onset of meningitis may be coincidentally timed with the induction of the spinal anesthetic.[3] In such cases, the causal relation between aseptic meningitis and the spinal anesthetic should be a diagnosis of exclusion. We believe that viral meningitis was not ruled out in the report by Easley *et al.*[1]

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In Reply:—We appreciate the interest of Dr. Abouliesh *et al.*[1] in our recent case report. We agree that it is not possible to differentiate viral meningitis from aseptic meningitis based on the cerebrospinal fluid findings and do not think that this differentiation is implied in our discussion of the case. More importantly, the suspected diagnosis of aseptic meningitis was subsequently further supported by the inability to isolate a virus from cultures of cerebrospinal fluid or from rectal and nasopharyngeal swabs. Although viral isolation may not always be possible, and the isolation of a virus is not conclusive evidence that the virus is the causative agent of meningitis, we think that this evidence strongly supports our conclusion of aseptic meningitis. Additionally, we were careful to state in the final paragraph that we could not prove a causal relation between the aseptic meningitis and the performance of the spinal anesthesia.

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Aerosolization of Lidocaine

To the Editor:—The apparatus described by Dr. Balatbat *et al.*[1] for applying lidocaine to the airway bears an uncanny resemblance to an arrangement that I first described in 1998.[2] I do appreciate, however, that it is not always easy to identify instances of previous publication, even with the most assiduous of literature searches, particularly if the publication in question happens to be correspondence. I say this with confidence because I made the same error myself; the arrangement was originally described by Dr. Tran in 1992.[3] Although others have judged my apparatus to be "more simple and ingenious" than that described by Dr Tran,[4] I suspect the same cannot be said for the arrangement described by Dr. Balatbat.

Whatever the merits of the various descriptions, it is worth emphasizing that the Tran-Mackenzie-Balatbat spray is a simple, elegant, and effective method for the topical application of drug sprays to mucosa-lined cavities, and is frequently adopted by those who have seen it in action, including otorhinolaryngologists.

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