in control nerves. Therefore, eventual causality remains unclear. Interestingly, the authors made a behavioural assessment within 1 week and found no functional deficits, but the tests used lacked discrimination of motor or sensory deficits, paraesthesia, or painful neuropathies. Therefore, functional data should be interpreted with caution. Objective evaluation of nerve injury, for example, myelin damage, is missing. Behavioural assessment is challenging, especially in larger animals such as pigs. For rodents, for example, rats and mice, validated and reproducible instruments (i.e., hot plate test, von Frey electronic, etc.) are available. On the basis of these many uncertainties, we feel that it is necessary to further clarify risks and consequences of various regional anaesthesia techniques before their acceptance and application in daily clinical practice.

**Conflict of interest**

None declared.

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**Emergence agitation in children**

Editor—I was interested in the article concerning emergence agitation in children after sevoflurane or desflurane anaesthesia. I anaesthetize a large number of pre-school children each year and my practice is mainly ENT. The authors found from their meta-analysis that propofol, ketamine, fentanyl, and preoperative analgesia all had a preventative effect on emergence agitation. I, like them, was slightly surprised that midazolam did not prevent emergence agitation. I would personally expect all agents such as sedatives, hypnotics, and analgesics to have a preventative effect on emergence agitation as they will all tend to give a smoother recovery.

I have long felt that a large number of pre-school children anaesthetized in my local hospitals suffer emergence agitation after operation when maintained with sevoflurane (we do not have desflurane available). For many years, I have maintained anaesthesia for these children, after induction of anaesthesia with either propofol or sevoflurane, with isoflurane. Isoflurane is possibly a slightly more difficult agent to use as it is more irritant to the airway than sevoflurane. I feel that the children maintained with isoflurane show less signs of emergence agitation. The children tend to wake slower than those maintained with sevoflurane but seem generally less distressed and their discharge from hospital is not delayed, compared with those maintained with sevoflurane.

As the authors mentioned, emergence agitation is distressing for recovery staff, ward staff, and parents and also puts the child at risk of self-harm and I feel that the simple substitution of isoflurane for sevoflurane for maintenance of anaesthesia decreases this risk. I have no evidence that isoflurane decreases the incidence of emergence agitation; indeed, some papers support the very opposite view but I would be interested if the authors came across any evidence to support or refute the suggestion that isoflurane leads to less postoperative emergence agitation?

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Editor—I thank Dr Huddy for his interest in our study. In response, two studies comparing sevoflurane and isoflurane have been published. These studies had divergent conclusions, despite similar methodologies especially concerning the preoperative pain management. However, the quantification of the emergence agitation was different, which may explain the conflicting results. It is established that the rapidity of the emergence is one of the factors favouring the agitation. Consequently, despite these conflicting results, isoflurane, because of its slower offset, may be considered as a prophylactic treatment of emergence agitation.

**Conflict of interest**

None declared.

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Successful intubation using retrograde trans-tracheal illumination after laryngoscope light source failure

Editor—We wish to describe a problem and solution that we encountered in a 32-yr-old female patient (ASA I) presenting for a radical vaginal hysterectomy. Anaesthesia was induced using fentanyl 2 \( \mu \text{g kg}^{-1} \), propofol 3 mg kg\(^{-1} \), and rocuronium 0.8 mg kg\(^{-1} \). Before direct laryngoscopy, it was noted that the light source for the laryngoscope was not functioning, even though in the preoperative check, the laryngoscope and light source were in working order. A replacement handle for the laryngoscope was not immediately available, and a blade change did not solve the problem. A flashlight was found in the anaesthesia machine drawer, and was applied to the patient’s anterior neck in the region of the cricothyroid membrane by an assistant.

Laryngoscopy was performed using the laryngoscope without a functioning light source. Visualization of the oropharyngeal structures was limited secondary to a lack of a light source on the blade; however, the anaesthetist was able to obtain a Cormack–Lehane Grade I view, and note that the retrograde translumination of the glottic structures resulted in excellent anatomic visualization, with the vocal cords ‘glowing red’ (Fig. 1). The tracheal tube was passed through the glottic opening, and intubation was confirmed by auscultation and quantitative end-tidal carbon dioxide capnography. Elapsed time from application of the flashlight to the anterior neck to confirmation of tracheal intubation was estimated to be 45 s. The patient’s \( \text{SpO}_2 \) remained at 99% throughout the procedure, and she was haemodynamically stable.

Successful airway management relies on the combination of a skilled clinician and properly functioning equipment. Laryngoscopes are instruments with multiple components that require regular maintenance for proper functioning. One component of the laryngoscope that is prone to failure is the light source.\(^1\) When a laryngoscope is used to facilitate tracheal intubation, visualization of the glottis is achieved through a combination of proper positioning of the laryngoscope and illumination of the glottis from a light source at the tip of the laryngoscope blade. The intensity of this illumination varies depending on the type of light source used,\(^2\,\,3\) and inadequate illumination may hinder proper visualization of the glottic opening. Total failure of the laryngoscopic light source makes visualization of the glottis extremely difficult, if not impossible. When back-up equipment is not available, as can be the case in resource-limited situations, such as medivac transports, or remote or developing medical facilities, an alternate technique must be used if tracheal intubation is required.

Antegrade trans-tracheal illumination of the neck is a well-established intubating technique as exemplified by the Trachlight\textsuperscript{TM} and other lightwand devices.\(^4\) To our knowledge, this is the first time that a retrograde trans-illumination technique has been described in the literature.

We believe that retrograde trans-tracheal illumination of the glottis to facilitate tracheal intubation using a flashlight (an item readily available in almost all parts of the world) may represent a simple, novel, inexpensive, and important rescue technique in times of equipment failure when back-up equipment is not available.

Conflict of interest

None declared.

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