Trauma and Emergency Medicine

Courtois CA, Trauma Emerg Med. 2025;2(1):5-10.

Commentary

Why it's important for emergency medical professionals to know about incest

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Received date: April 17, 2025
Accepted date: June 09, 2025

Commentary

It is my hope that the title of this commentary makes you curious—why is it important as a professional in an emergency medicine setting to know about such a difficult and aversive topic? You might be asking: haven't we as a society been inundated enough with disclosures and information about other forms of sexual abuse and sexploitation, perpetrated by celebrities, clergy, teachers, military colleagues, and sometimes by relatives? Haven't we had enough and why do we need to know more? And why in the emergency department? What does that have to do with us? In this contribution, my aim is to provide information in answer to these questions.

My study of incest began with a survey of a volunteer sample of adult women survivors of incest, the topic of my doctoral dissertation in the late 1970s at a time when rape and incest were entering public consciousness as a result of the 2nd wave Women's Movement. The findings regarding self-described aftereffects in these women formed the basis of my book *Healing the Incest Wound: Adult Survivors in Therapy* [1,2]. Through my research and study, I came to recognize incest as a major social problem with high potential for profoundly negative impact on the individual victim, the family, and society as a whole. And I came to understand why it is different from other forms of child sexual abuse perpetrated by strangers and how family perpetration greatly compounds its dynamics and aftereffects.

Defining Incest and Reasons for Knowing about It

Around the globe and in most cultures and societies, the very word "incest" carries extremely negative connotations and brings up feelings of revulsion and loathing. These reactions are largely due to the widespread cross-cultural taboo and prohibition against sexual relationships between relatives, especially parents and their children. Defined broadly, incest refers to sexual contact between individuals who are related biologically (through family genetic ties) or socio-legally/affinally (through marriage, adoption, or other close family role such as paramour or common-law partner). It has primarily referred to sexual exploitation of a minor child by an adult relative-- and as a form of child sexual abuse--but it also refers to adult to adult and child to child sexual contact. Historically, its taboo status is due primarily to its potential for conflicted and rivalrous relationships between family members that have the potential to destroy nuclear and extended family units and beyond and due to birth defects and other negative effects on offspring. Incest has been found to have transgenerational dynamics and its occurrence in one generation, if unchecked and untreated, can lead to occurrence in the next, sometimes by the same family member and sometimes by others as well. Multiple family perpetrators of the same victim or of others are not uncommon, nor are multiple victims in one family. As research on effects has accumulated over the course of the past 60 years, it has further become obvious that pathology is involved on the part of most perpetrators and that the damage caused to its victims can be the source of lifelong anguish and suffering.

My focus here is to provide the rationale for why it is important to continue to break the silence that has historically surrounded the topic of incest and to continue to uncover its secrets. Here are four primary reasons in support of this focus.

First, its *prevalence*. Despite being taboo and the subject of powerful prohibitions across cultures, incest prevalence is widespread. Sociological research on child sexual abuse undertaken during the 1970s and 80s, found a shockingly high rate of 30-40% of girls and 20-30% of boys who were victims of such abuse, *much of it perpetrated by family members and related and trusted others who had power over or responsibility for the child*. These findings led one researcher to remark that the taboo was not on incest occurrence but rather on its identification, disclosure, and acknowledgement. At present, additional studies from around the globe continue to point to a widespread prevalence, largely fueled by the power imbalance between men and women and the dynamics of misogyny and patriarchy in male dominated societies and as espoused in some cultures and religions. Transgenerational patterns and dynamics have been found in some families where incest has been found to be endemic. More recently, its occurrence may be stimulated by incest themes and fantasies found in a great deal of pornography, child porn in particular, and on social media.

What to make of this discrepancy between such a stringent ban and the reality? Perpetrators' pleas and threats to victims to keep the secret (often in the interest of continuing the abuse without interference or intervention), and resulting silencing and internalized shame and self-blame in victims have all contributed to keeping its true rate of occurrence shrouded and unavailable. Social mores have continued the avoidance and revulsion about the topic rather than facing and admitting it, thus privileging abusers over victims who most often are disbelieved and blamed/shamed if they disclose. To wit, as an article in the Atlantic magazine shockingly entitled "America Has an Incest Problem" boldly declared: American society has not accepted the full depth and scope of incest and its societal (as well as familial and individual) severity and ramifications, to its own detriment [3]. The same can be said for most countries. As a recent example, following the results of the *#MeToo* movement in the US that led to the unprecedented disclosure of incestuous and other forms of sexual abuse and assault, in France the *#MeTooInceste* movement resulted in thousands of victims revealing the abuse that they had experienced as children at the hands of relatives [4].

Adding another and more definitive dimension to the prevalence estimates, DNA testing and its widespread availability through such services as AncestryDNA and 23andMe has provided irrefutable new biological evidence of the true prevalence of incest and how hidden it continues to be [5]. Through genetic testing, individuals have learned the true identity of relatives and the degree of relatedness between them (e.g., finding out that their grandfather, brother, uncle or cousin is really their biological father or that their mothers were pressured to adopt them out due to the social stigma that would ensue to the family if their true birth status became known), often creating shock and personal and family crises when and if disclosed.

And finally, in the US, the reversal of abortion rights has led a number of states to prohibit abortion in cases of rape and incest, a major change with serious ramifications. The birth of babies conceived through sexual assault and resultant pregnancies with no abortion option creates another confounding situation for victims, abusers, and their families, if and when paternity becomes known. This is especially the case when it is due to incest. Many of these babies will be met with highly ambivalent responses. Some will be immediately given up for adoption, often without their true parentage revealed while others will have their conception circumstance questioned, whispered and gossiped about, and held against them for life. Such family secrets can have a profoundly negative impact. The legal system that now mandates these births has, as of yet, not found ways to provide assistance for victim/mothers nor for other members of the family. Nor are efforts at prevention in place.

I recall one mother I consulted with who had not yet disclosed his paternity (her grandfather) to her son due to her profound shame but who had come to believe that it was his right to know. She had raised him as a single mother and had always kept his true paternity a closely held secret within her extended family. She cried copious tears in our session about her ambivalent feeling of love and hatred *towards her son* and her ongoing guilt for how she had mistreated him over the course of his upbringing. He resembled the perpetrator and was a daily reminder to her of a long-ago series of incestuous rapes. Her grandfather-abuser had recently died, setting off flashbacks of his abuse that were additionally overwhelming her. She was seeking counsel and she certainly needed support. Should she tell her son? Who would believe her and how could she continue to manage?

Second, incest is a *form of interpersonal violence and trauma, perpetrated deliberately and often with premeditation by biologically or other related individuals*, distinguished from other forms of trauma that are accidental and unintended, and thus are *impersonal* in causation. In contrast, interpersonal violence is usually quite intentional. Prior to the abuse, there may be a positive relationship between victim and perpetrator, but as the relationship is used to provide accessibility of the victim and "cover" for the abuse, the relationship becomes forever tainted. Moreover, the relationship itself may be used as a means of rationalizing the aberrant, exploitive behavior, usually by misinforming the child about what is happening while blaming them for its occurrence. Adding to this dynamic is the fact that the perpetrator is usually more powerful and influential than the victim (and, in the case of child abuse, more physically and emotionally mature and with responsibility for the victim's welfare and protection), creating a situation ripe for dominance, influence and coercion. Finally, coercive control includes demands for secrecy and non-disclosure by the abuser (sometimes enforced with ongoing threats to self or others), another aspect of the traumatization (forced silence) that leaves the victim uncertain and left to deal with and make sense of what happened and why. More often than not, the victim assumes the blame while experiencing enormous shame. And due to the relationship they have with the perpetrator and these feelings, they typically maintain their silence and do not disclose. In the process, whether they mean to or not, they protect the perpetrator and keep their victimization hidden.

Abuse by a "responsible or trusted other", especially one who is related in some way, particularly a parent or parent-substitute, creates a profoundly damaging dual relationship that is confusing for the victim (for example, one of my clients would question her father's motivation in having sex with her and would bemoan that she just wanted him to return to being her dad and be like other dads). Profound betrayal is involved in what is now identified as *betrayal trauma*, interfering with the ability to feel secure in relationships and to trust others. As another one of my clients lamented one day, "If I can't trust my parents, who can I trust?" The question becomes, is

the abuser parent or lover or both? friend or foe, or both? And in the case of parent-child incest, what is the relationship with the non-offending parent, as parent or rival or as non-protective bystander or even co-offender? In yet another twist in the "blame game" surrounding incest, mothers, much like their daughter victims, are often blamed in cases of father/step-father-daughter incest, even when its occurrence has been kept carefully hidden from them.

Betrayal trauma theory has developed to offer more detailed information about the consequences of these relational breaches. Research findings have repeatedly demonstrated that the *closer the relationship between victim and perpetrator* (high betrayal)*, the greater the severity of the aftereffects*. And the inability to differentiate friend from foe creates a generalized mistrust of others and their motivations, while simultaneously creating what has been identified as "betrayal blindness" in the victim, a dissociative-type process that paradoxically renders them more susceptible to re-victimization in other relationships over time [6]. A tragically high rate of such retraumatization in child sexual abuse and incest victims in particular is a common research finding.

The most common incest abusers are fathers and step-fathers (the latter by a large measure, possibly due to their lack of a biological bond with the child victim who they have not raised from birth, found to be risk factors), followed by brothers, uncles, and male cousins. Abuse by females occurs with much less frequency, but is not unheard of. It can create additional confusion and shame due to being atypical. The psychological profile of the average incest offender has not yet been definitively determined, with some having profiles that appear normal and others that are high in psychopathology. More investigation of perpetrators is definitely necessary, as is the need for effective sanctions and treatment methods. As with rapists, most incest perpetrators go free and it is the uncommon case that results in a prison sentence or in rehabilitation efforts.

Third, *incest involves many types of direct sexual contact and behaviors* in addition to other more indirect sexual activities. In addition to physical/sexual forms of incest up to and including intercourse, emotional forms have been identified--where the relationship has been sexualized or eroticized in some way--such as sharing pornographic images with a child, engaging in or encouraging nudity and voyeurism, behaving seductively or dressing provocatively--but where actual sexual contact does not occur. The range and objective severity and perversity of activities is very broad, yet the victim's response cannot only be attributed to severity and physical intrusiveness. As just noted, the degree of relatedness and betrayal is significant, as is the victim's perceptions and beliefs about the behavior and their involvement or role. Additionally, sexual abuse that occurs in relationships involving individuals in authority can have *incestuous connotations* (e.g., clergy abuse by a *father* figure who is a *stand-in for God the Father; a trusted mentor who is like a "second parent" who sexualizes the relationship*) [2].

Females are, on average, more likely to be incestuously abused, but it has emerged that there is a significant degree of male incest that has only more recently been identified, largely as a result of the clergy abuse scandal and cover-up in the Catholic Church that primarily but not exclusively involved male victims. Sexually abused males have tended to be even more reluctant to disclose abuse because being a victim violates the traditional male gender role and can lead to questioning of one's sexual identity and orientation in the case of male-on-male incest/sexual abuse. Both of these issues bring additional confusion and consternation to the male victim. Tragically, some--but not all and not the majority--cope by physically or sexually victimizing others, both inside and outside the family, in identification with the abuser or as a means of seeking some sort of mastery over their own experience.

In another variant that tends to defy belief and yet has proven to be an unfortunate reality, incest may extend beyond the nuclear or extended family, usually due to perversion and psychopathology and, in many cases, for the purpose of financial gain. Parents and others--often in group or organized settings--may engage their child/children in incestuous behavior and/or make them available for sex for the purpose of producing child pornography as well as for prostitution and trafficking to other adults [7]. Another secret, uncovered quite recently, is that some incest that begins in childhood or adolescence extends into adulthood or never ends [8]. Although these are the atypical case, they are not unique and may occur more than has been recognized. More variants that are as yet unknown may still come to light.

Fourth, *incest is a crime and is not victim-less or inconsequential as many perpetrators (some of whom are organized in pro-incest groups) would like the public to believe.* Research has conclusively documented a range of consequences that are, on average, severe and long-lasting across virtually all life domains. These emerge in line with age- and stage-related developmental tasks which may be accelerated or degenerated by the abuse, thus throwing the child off of their personal developmental trajectory. All forms of incestuous contact should be seen as *potentially traumatic* events, yet it should be recognized that not all victims will be traumatized nor will they respond in the same way. Among other factors, immediate intervention following disclosure, prevention of further abuse, and emotional support and understanding rather than blame can reverse some of the traumagenic dynamics at play. Therapy that is incest- as well as trauma-informed is justified as both initial and long term interventions.

However, when such intervention is lacking and abuse continues and progresses in severity and physical intrusiveness in conditions of entrapment and forced silence, its traumatic impact sets off complex stress-related neurophysiological changes that, in turn, can set off immediate acute posttraumatic and other emotional and behavioral responses. Over time and without intervention, these often morph into chronic posttraumatic symptoms that meet criteria for Posttraumatic Stress Disorder (PTSD), acute, delayed or chronic. These are often accompanied by many other diagnosable responses and conditions (i.e., depression, anxiety, dissociation, alexythimia and difficulties with emotional regulation, conduct and attention disorders, problems with identity and self-worth, somatic and medical conditions, difficulties in relationships with others and sexual problems and dysfunction, self-injury and suicidality, and spiritual distress, among the most common) leading many experts to opine that *incest, as the foremost form of complex or compounded trauma, should be considered as transdiagnostic*. These responses and symptoms may be quite apparent but are usually not recognized as posttraumatic responses since, as noted above, victims typically don't disclose, even when asked directly. It is also the case that, paradoxically, when a child does dare to make a disclosure, they are likely to be disbelieved or their report denied or minimized. Instead, they are often criticized or stigmatized for their symptoms, as the origin of those symptoms remain hidden and uninvestigated, creating another level of trauma, referred to as *second injury*.

In 1992, Dr. Judith Herman coined the term *complex trauma* (also recognized as *complex interpersonal developmental trauma* to distinguish it from more impersonal or unintentional trauma that begins in adulthood) and in recognition of its transdiagnostic consequences proposed a new diagnosis of Complex PTSD [9]. This diagnosis was added to the *International Classification of Disorders-11* [10] as a "sibling diagnosis" to PTSD but with three additional and more developmental criteria labeled Difficulties with Self Organization (DSOs): 1) emotional dysregulation, 2) negative identity development and self-worth, and 3) problems relating to others and developing satisfactory relationships, along with an increased propensity for dissociation. Incest is the index trauma for this diagnosis due to its defining characteristics and its potential for longstanding and even lifelong onerous symptoms across life domains and increased risk for ongoing revictimization.

Implications in Emergency Medicine Settings

Professionals in emergency medical settings, might have victims present in many ways and hopefully have protocols in place for intervention and treatment. As each case of incest is unique, its consequences and presentations will be similarly unique. Some of the ways these individuals might show up in an emergency department are as follows, although there may be many others:

- Child victims of all ages who have just disclosed or whose abuse has been detected or reported to authorities by mandatory reporters such as teachers or child care workers or by others. This often results in a crisis presentation. It is important to recognize that the mandatory reporter role may extend to the emergency medical professional treating a child for incest/sexual abuse so it is important to know state laws and to keep careful and accurate records of all interactions. Furthermore, professionals should be aware that children in such situations are often terrified and may have been threatened with dire consequences if they ever told. They often recant their disclosures in the face of intervention, in an attempt to protect or obey the perpetrator/relative or non-offending parent in the case of parent-child incest, or due to fear of punishment or rejection/abandonment or other consequences. A recantation does not mean that abuse did not occur and providers must be aware of the likelihood of children reversing their allegation or disclosure and not censure them for doing so or automatically buy into their denial. Careful assessment and non-judgemental and neutral documentation are necessary. Expert child advocacy workers are often required for consultation, assessment, and intervention.
- The child victim usually a comprehensive and sensitive medical exam, including the use of a rape kit (with testing for STDs) and evaluation and treatment of genital or other injuries. Explaining procedures and how they will occur is in the interest of helping the child (or older victim) understand and allaying their anxiety. Once again, accurate and complete record-keeping of findings and treatment is a necessity in such a situation, especially when child welfare agencies and law enforcement become involved.
- Latency age and adolescent victims may respond similarly but in accord with their age and stage of development. As they are older and stronger, they may be in the throes of making distance or separating from the abuser as they individuate and try to fit in with their peers, a circumstance that may create a crisis for the abuser and the family. Adolescents may be more apt to show anger and even to be defiant and uncooperative. Since pregnancy risk increases in this age group, including those with early onset of puberty, pregnancy testing should be included in the medical work-up, along with testing for STDs. Where an incest pregnancy is a possibility or is determined, providers now must follow the state laws regarding an abortion option. Recall the case of the 10 year old Texas child who had been impregnated by her uncle and who needed to travel to another state for an abortion soon after the Supreme Court handed down the Dobbs decision. Following changes in state law, Texas medical professionals refused to perform an abortion and the doctor who provided an abortion in a state where it remained legal nevertheless had charges brought against her! Again, child welfare agencies and law enforcement personnel may be needed to discuss options and guide decision-making for the facility and staff as well as the victim and family.
- As a consequence of past or current abuse and in response to additional crises such as an incest pregnancy, other abuse in the family, media reports, or many other life stressors, victims can present as psychiatric emergencies. Such presentations may include self-harm, sometimes at alarming levels of danger and damage, and suicidality including attempts and completions. Cases of murder-suicide have also been documented post-incest reports and confrontations. Psychiatric diagnoses such as major depression; anxiety disorders; dissociative processes and disorders (including depersonalization, derealization, fugue states, and other altered mental status up to and including switches in self-state as seen in dissociative identity disorder); PTSD (including such classic symptoms as flashbacks and other modes of remembering or catatonic-type shutdowns of memories and emotions, along with physiological hyper-arousal and hypervigilance/paranoia-like symptoms); CPTSD (including extreme mistrust of authority figures, including doctors and nurses, negative sense of self, and avoidance symptoms); misuse and abuse of alcohol and other substances; bi-polar disorders; and catatonia, delirium and psychosis may be implicated. There may also be a range of what are often confusing medical conditions which may defy diagnosis and be the result of long-term neurophysiological alterations due to the traumatization whether endured in the past or continuing in the present. Both old and new physical injuries may be part of the presentation and require evaluation and treatment. In the event that abuse is ongoing, pregnancy and rape testing are warranted.
- Victims of any age and other family members who decompensate or are otherwise in shock after learning the truth about an individual's paternity or the circumstances of an adoption from the results of genetic testing. They too might be thrown into a psychiatric crisis and to be in need of social services and other follow-up treatment, following initial assessment and stabilization.
- Older and elderly victims (and abusers) especially those with age-related physical frailties and illnesses including dementia and Alzheimer diagnoses. The limitations imposed by age-related decline may be evocative cues to the return of memory and the delayed onset of symptoms of PTSD. Since symptoms of dementia may resemble some of those associated

with PTSD, differential diagnosis is necessary. These patients may have a high degree of agitation and depression and have the need to make late-in-life and even deathbed disclosures, confrontations, confessions, apologies, etc. Gerontologists and other specialists may provide these individuals with needed support and treatment.

- The impact on staff treating these situations. Vicarious trauma and burnout have been identified as common in service providers who are "on the front line and in the trenches" especially when dealing with physical or psychological forms of trauma in acute circumstances such as an emergency department. While it is assumed that emergency personnel have the requisite training to deal the daily onslaught of physical types of trauma, they may not have the same for psychological forms of trauma. Service administrators should include basic training about psychological trauma and its possible consequences, including particular attention to incest/child sexual abuse and ways they might present in the emergency department in order for staff to be knowledgeable versus taken aback when they face such a daunting and unsettling situation. Leadership should also provide resources for ventilation, de-briefing and support when staff experience vicarious trauma due to the cases they treat.

Conclusion

Professionals and the general public must begin to appreciate that the majority of child sexual abuse is incestuous and that its typical consequences are serious and long-lasting. Just as it has been for other forms of child physical and sexual abuse, it is quite difficult for caregivers to accept that closely related, ostensibly responsible and loving adults including parents and others would sexually prey upon their own minor children in violation of moral and ethical standards. However, it is this very dynamic, the betrayal of the relationship, that is critical to accept and understand as it is what makes incest so psychologically confounding and damaging. Providers from all treating professions, particularly those on the front line such as emergency medical workers, can begin to mitigate some of the most onerous effects of incest by being knowledgeable and professional in their interactions by treating victims with respect, understanding, and kindness, by not automatically stigmatizing or shunning them, and by being willing to offer them support.

Professional training regarding incest as the most common and the most damaging form of child sexual abuse is generally lacking and is long overdue. Emergency medicine program administrators should include these issues in staff training and then provide avenues for support and de-briefing in the aftermath of attending and responding to such cases. Treatment efforts for victims have developed but much more is needed in terms of intervention for the entire family where incest occurs and for prevention efforts.

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