

CORRESPONDENCE

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Endotracheal Tube is Not Necessary for Laryngeal Microsurgery

To the Editor:—The recent correspondence concerning ignition and ventilatory problems during CO₂ laser laryngeal microsurgery^{1,2} suggests a continuing challenge to the clinical anesthesiologists in this realm. I submit that, although not widely appreciated, one method to avoid such problems is to use no endotracheal tube at all. Such a method has been successfully utilized since 1961 for routine laryngeal microsurgery by myself and my colleagues.³

Since 1978 we also have utilized this method for CO₂ laser microsurgery in approximately one hundred laryngeal and tracheal cases without untoward incident. Indeed, for the extirpation of tracheal lesions the presence of an endotracheal tube may preclude access to the anatomical sites of the lesions.

No instance of pulmonary pathology due to smoke inhalation has been noted in any of these spontaneously breathing patients, and in fact, such spontaneous ventilation actually aids considerably in dissipating

smoke to improve the surgeon's vision. Perhaps other clinicians will find this technique useful in avoiding the known hazards of CO₂ laser with endotracheal tubes in microlaryngeal surgery.

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3. Talmage EA: Safe combined general and topical anesthesia for laryngoscopy and bronchoscopy. *South Med J* 66:455-459, 1973

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ASA Brochure on Waste Anesthetic Gases Fails to Consider Prevention

To the Editor:—I am chagrined that an organization of which I am a member (ASA) should publish a brochure* on reducing pollution of operating rooms by anesthetic gases with no consideration given to simply *not polluting* the atmosphere of the room, *i.e.*, by using only such amounts of agents required by the patient (closed system).

"Waste anesthetic gases" are the first three words of the title page of the brochure. Wouldn't a thrust by the ASA to *not waste* gases be a possibility?

The brochure states, "We do not advocate marked

alteration in anesthetic techniques . . ." If using a closed system is agreed to be such a "marked alteration" that it not even be considered, it would appear that we are too lazy or narrow in our outlook to have the term "scientific" applied to our activity.

Nurse anesthetists use the closed system quite well. Is this too demanding or too difficult for an anesthesiologist to even consider?

It's too much to expect that changes in techniques will be universally rapidly adopted, but elimination of waste should at least be *considered*.

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* Waste anesthetic gases in operating room air: A suggested program to reduce personnel exposure. The American Society of Anesthesiologists Ad Hoc Committee on Effects of Trace Anesthetic Agents on Health of Operating Room Personnel, R. I. Mazze, Chairman.