nerve temperature (0°–40° C) and conduction velocity (per cent of normal) for myelinated and nonmyelinated nerve. From 17°–40° C both plots are almost congruous (certainly there is no statistical difference). Since our experiments were conducted at 22°–24° C, I don't believe this criticism has any validity.

In addition, Heavner and de Jong[5] reported experiments at normal body temperature with rabbit sympathetic trunk (not desheathed) exposed to lidocaine that duplicated our results (on B and C fibers) with desheathed rabbit vagus at room temperature. They also found that B fibers were more sensitive than C fibers to the action of local anesthetic.

The last point he makes is true but only marginally meaningful. Experiments done at a fixed repetitive tetanic rate are also nonphysiological. Neural traffic during stimulation usually consists of a sequence of APs at varying frequencies, so that neural signals consist of frequency modulation patterns. I have never seen any experiment designed to recognize this fact.

Finally, I note in Galindo's comments (quoting Franz and Perry[2]) that B is compared to A fibers, C is compared to B fibers, but no relationship is established between A and C fibers. Our study very carefully examined, under identical conditions, the relationship between A, B, and C fibers.

I agree with the general tenor of Dr. Galindo's comments. I also wish experimental design was more sophisticated so that results could be directly evaluated in the light of normal physiology. I will gladly accept any criticism that constructively makes this possible. However, I also get the impression that Dr. Galindo is as imprecise in his conclusions as the quoted articles.

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Anesthesiology
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Another Use for the Fiberoptic Bronchoscope

To the Editor:—The flexible fiberoptic bronchoscope is a valuable aid in intubating patients, especially when difficulty with intubation can be predicted. Recently, Rosenbaum *et al.*[1] described use of the instrument in changing endotracheal tubes. We wish to report yet another use for the fiberoptic bronchoscope: as a guide to proper placement of tracheostomy tubes.

Most tracheostomies are performed with an endotracheal tube *in situ*. Once the trachea is exposed surgically, the endotracheal tube is withdrawn and the tracheostomy tube positioned within the trachea. Occasionally, due to loss of exposure or anatomic variation, the tracheostomy tube cannot readily be inserted in the trachea. Unrecognized paratracheal placement of the tube can also occur. The authors have witnessed both complications on more than one occasion. It is therefore suggested that a fiberoptic bronchoscope be inserted into the indwelling endotracheal tube via a Rovenstine or similar adapter prior to withdrawal of the endotracheal tube (fig. 1). Under most circumstances this will be done by the anesthesiologist as the majority of elective tracheostomies are performed in the operating room with an anesthesiologist present to monitor the patient.

In addition to verifying proper placement of the tracheostomy tube, the endoscopist can examine the trachea for secretions, areas of inflammation, and other abnor-

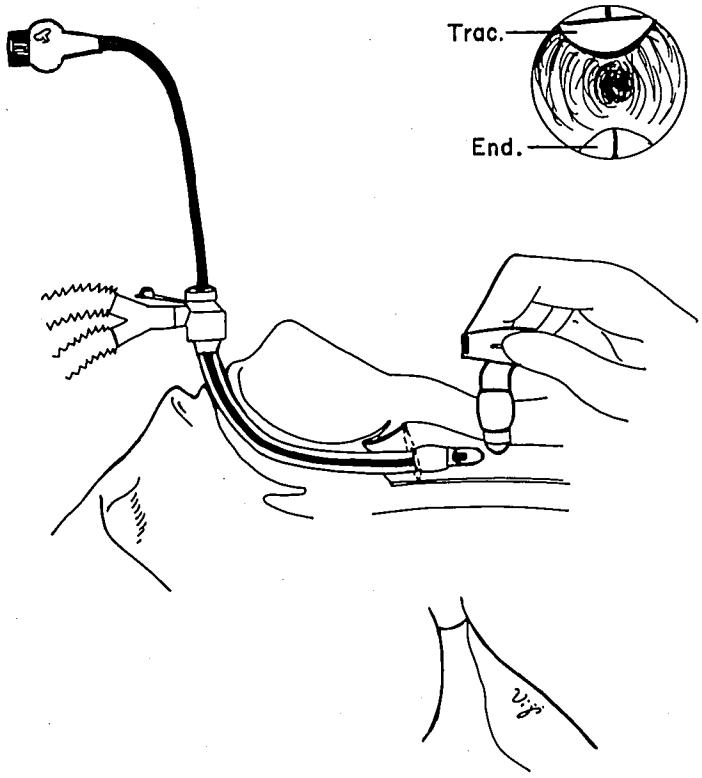

FIG. 1. Insert showing view through bronchoscope: tip of tracheostomy tube entering trachea and tip of endotracheal tube also visible. Vertical lines on tubes represent radiopaque markers of Portex® tubes.

malities. The anesthesiologist is also afforded the opportunity to gain facility with use of the bronchoscope.

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Cordis Introducers: CVP Measurement with Fluid Infusion

To the Editor:—Cordis introducer catheters are presently utilized routinely for obtaining and maintaining central venous access.[1] The catheters are manufactured in 5 to 8-Fr sizes, the 8-Fr size being the most commonly available because of its compatibility with 7-Fr adult pulmonary artery catheters. Due to the convenience and relative safety of insertion by the Seldinger technique, these introducers are often used for central venous pressure monitoring in patients who do not require the added risk of pulmonary artery monitoring. This has the additional benefit of permitting the rapid placement of a pulmonary artery catheter through the hemostatic valve of the introducer if the patient's condition deteriorates and such monitoring becomes indicated. The introducer also provides a large-caliber venous access for the rapid infusion of fluids. When using the introducer for such rapid infusions or for continuously infusing vasoactive drugs, the single sidearm port on the Cordis does not