

for the initial puncture. We use a 20-gauge catheter-over-needle set for the initial puncture, confirm a venous waveform and pressure once the 20-gauge catheter is passed into the vein, and then pass a 0.025 guidewire over which a larger introducer sheath can be passed.⁴⁻⁵ In this manner carotid puncture, if it occurs, is with a small needle which is less likely to result in serious morbidity. 3) The meticulous manner in which Goldfarb and Lebrec recorded their experience suggests that persistence pays off, since in 3% of their patients six "thrusts" were necessary to locate the vein. We have the impression such persistence is associated with more frequent carotid artery puncture although we did not record the exact number of attempts in our series.³

In conclusion, we are impressed with the success of Goldfarb and Lebrec, who have clearly demonstrated that internal jugular vein cannulation may be performed in the presence of severe defects of hemostasis and, in pressing circumstances, may be indicated. However, for most cases involving defects of hemostasis, we suggest that alternate routes be considered. In all cases we urge use of the Seldinger technique to permit initial cannulation with a small, short needle and confirmation of the venous waveform and pressure before proceeding to the larger catheter.

Anesthesiology
57:346, 1982

A Simple Solution for Collecting Drainage from a Nasogastric Tube

To the Editor:—The open end of a nasogastric (NG) tube is often a necessary nuisance at the head of the operating table. It may require periodic suction or may drain spontaneously (not infrequently onto the anesthesiologists' scrub clothes or shoes). In the former situation, the application of suction with full vacuum may damage the gastric mucosa. In the latter, the open end of the NG tube must be attached to some sort of container. An empty iv solution plastic bag serves this purpose as well as provides a convenient method of measuring gastric output. The NG tube is connected to the port which normally accepts the iv tubing. The other port used to inject additives into the bag must be cut. Negative pressure

may be applied periodically to the system by attaching the port which is left open to the atmosphere to the vacuum system. It is advisable to allow some degree of leak in the connection.

JORGE TORRETTI, M.D.
Resident (in-training)
Department of Anesthesiology
State University of New York
Upstate Medical Center
Syracuse, New York 13210

(Accepted for publication April 20, 1982.)

Anesthesiology
57:346-347, 1982

A Few Observations and Suggestions Regarding the Art of Public Communication

To the Editor:—The continuing necessity to improve my own delivery has made me a keen observer of the art of speaking at meetings. Over the last ten years, I have

attended numerous anesthesia symposia and congresses in England, Europe, America, South Africa, and the Far East. One is struck by the propensity of so many speakers

NORIG ELLISON, M.D.
Associate Professor of Anesthesia
DAVID R. JOBES, M.D.
Associate Professor of Anesthesia
ALAN JAY SCHWARTZ, M.D.
Assistant Professor of Anesthesia
Department of Anesthesia
University of Pennsylvania
3400 Spruce Street
Philadelphia, Pennsylvania 19104

REFERENCES

1. Goldfarb G, Lebrec D: Percutaneous cannulation of the internal jugular vein in patients with coagulopathies: an experience based on 1,000 attempts. *ANESTHESIOLOGY* 56:321-323, 1982
2. Klineberg PL, Greenhow DE, Ellison N: Haematoma following internal jugular cannulation. *Anaesth Intensive Care* 8:94-95, 1980
3. Ellison N, Schwartz AJ, Jobes DR, Greenhow DE, Stephenson LW: Avoidance of carotid artery puncture sequelae during internal jugular cannulation. *Anesth Analg (Cleve)* 61:181, 1982
4. Ellison N, Jobes DR, Schwartz AJ: Cannulation of the internal jugular vein: a cautionary note. *ANESTHESIOLOGY* 55:336-337, 1981
5. Seldinger SI: Catheter replacement of the needle in percutaneous arteriography: new technique. *Acta Radiol* 39:368-376, 1953

(Accepted for publication April 26, 1982.)

to read their papers. Matters are made worse by the simultaneous projection of obviously old or dirty (not pornographic) slides.

Surprisingly, these sins are not committed infrequently by speakers of both national and international repute, their performance sharply contrasting with some equally illustrious but far more entertaining and, therefore, communicative orators whom I have had the privilege and pleasure of hearing. On one occasion, I recall a famous anesthesiologist and researcher projected numerous slides depicting several paragraphs in tiny print, photographed directly from a book, which he then proceeded to read verbatim! Presumably, the speaker impolitely, either considered the audience illiterate or appreciated the illegibility of the information appearing on the slides from the outset.

Speakers at meetings generally should be more considerate of their audiences, many of whom have traveled hundreds of miles and paid substantial fees to be there. Good communication involves simple but well-established principles designed to allow spread of important information in an interesting and entertaining fashion.

Anesthesiology
57:347-348, 1982

These guidelines are well-covered by several books and articles which should be essential reading to all who aspire towards improving their performance and ability to communicate scientific information from a public podium. Two references I have found of particular value (and very entertaining reading) are listed below for the benefit of those interested in making enjoyable contributions to future symposia and congresses.^{1,2}

JOHN W. DOWNING, M.D.
*Visiting Professor, Anesthesiology
Acting Head, OB-Anesthesia
University of Washington
Seattle, Washington 98195*

REFERENCES

1. Calman J, Barabas A: Speaking at Medical Meetings—A Practical Guide, Second Edition. London, Williams Heineman Medical Books, Ltd., 1981
2. Meadow R: Speaking at medical meetings. *Lancet* 2:631-633, 1969

(Accepted for publication April 27, 1982.)

An Improved Technique for Celiac Plexus Block May Be More Theoretical Than Real

To the Editor:—The article by Singler was read with interest.¹ Dr. Singler suggests using a more vertical approach for needle placement and placing the tips anterior to the crura of the diaphragm so that neurolytic solution bathes the celiac ganglia and plexus rather than the splanchnic nerves in the retrocrural space. In theory this

would seem optimal; however, in practical clinical application the recommendation has several faults.

Location of the celiac neural axis by CT scanning is fraught with diagnostic problems, in particular, differentiating the celiac artery from the superior mesenteric artery on transverse sectioning. A more practical problem

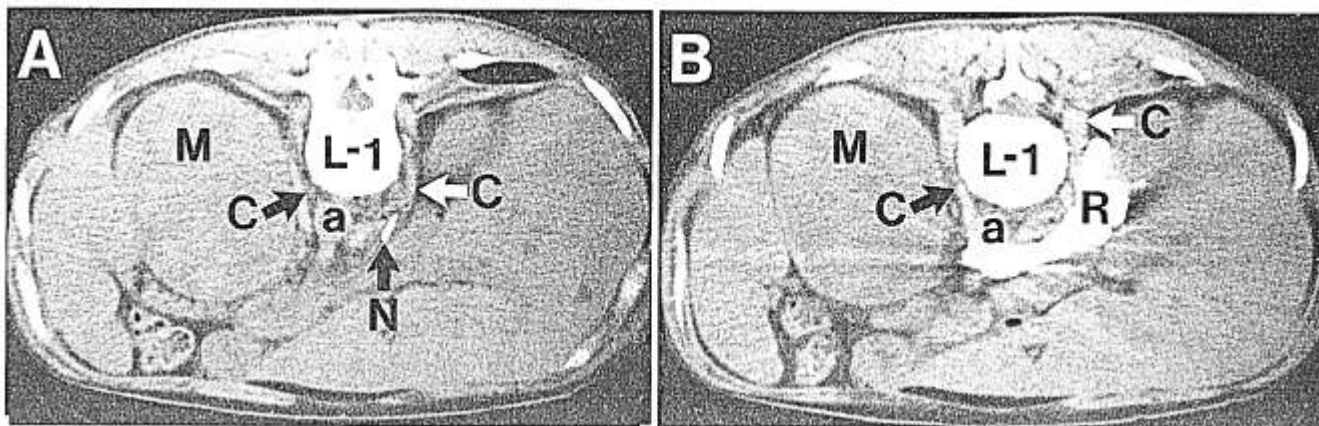


FIG. 1. When the transcureal approach is employed, usually only one needle is placed at L1 because, even if computed tomography is used, a needle inserted on the left side would in most instances of necessity pass through the aorta prior to puncturing the crus of the diaphragm, as can be ascertained from the above reproductions of the CT scans. A. Needle's bevel anterior to crus of diaphragm. B. Spread from needle in A of 50 ml of radiopaque material (25 ml of absolute alcohol, 18 ml of 0.75% bupivacaine, and 7 ml of meglumine iohalate USP 60 (600 mg/ml), osmolarity = 1.5 m Osm/ml, that is, Conray). L1 = body of first lumbar vertebra. C = crura of diaphragm. a = aorta. M = massive growth of lung metastasis in left adrenal gland. R = spread of radiopaque solution.