

Participation in the ASA Preceptorship program was gratifying during the 8-week course. To have three out of five students eventually enter anesthesiology residency programs was worth the inconveniences encountered during the 8-week program. Exposure to the private practice of anesthesiology is one of the most effective means to build the image of our specialty. Each anesthesiologist in private practice should evaluate their own environment and consider participation in the ASA Preceptorship program.

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*(Accepted for publication June 21, 1983.)*

Anesthesiology  
60:79, 1984

### The Optimal Test Dose for Epidural Anesthesia

*To the Editor:*—For 7 years I have used a test dose of 2 ml 0.5% bupivacaine with 1:200,000 epinephrine, and it is good to find support from American colleagues.<sup>1</sup>

We tested 100 young, fit, gynecologic patients by giving intravenously either 1) 0.25% bupivacaine plain, 2) 0.25% bupivacaine with 1:400,000 epinephrine, 3) 0.5% bupivacaine plain, or 4) 0.5% bupivacaine with 1:200,000 epinephrine in an amount of 2 ml. There were 25 patients in each group. Only in the group receiving 0.5% bupivacaine plus 1:200,000 epinephrine was it possible to be sure than an intravenous injection had occurred. The plain solutions never caused any symptoms or signs.

We also injected various suggested test doses intrathecally in patients requiring vaginal hysterectomy. We used 0.5% lidocaine; 0.25, 0.375, and 0.5% bupivacaine plain, and 0.5% with epinephrine. Only the 0.5% solutions of bupivacaine gave reasonably reliable results, but it was often not easy to be sure a block had occurred until 10–15 min had elapsed. At 5 min all 35 patients could move their legs. Unless evidence of perineal analgesia was sought, often nothing at all was reported by the patient. Where there is still doubt, hyperbaric dibucaine 1:200 solution 0.5–1 ml injected down the epidural needle will very quickly (2–3 min) and safely give the answer if in-

trathecal injection has occurred. The routine use of dibucaine would add to the expense of the technique and its use is confined to problem cases. Thus, 2 ml 0.5% bupivacaine with 1:200,000 epinephrine is used as the routine test dose.

In the laboring patient, pain relief may develop when 2 ml 0.5% bupivacaine with epinephrine is given inadvertently into the subarachnoid space. This is a very useful safety factor and should alert the clinician to the probable occurrence of spinal analgesia.

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*(Accepted for publication July 7, 1983.)*

Anesthesiology  
60:79–80, 1984

### Another, Yet Simpler Device for the Identification of the Epidural Space

*To the Editor:*—Mustafa and Milliken suggested the use of a piece of clear plastic intravenous extension tubing filled with drops and bubbles, attached to a Tuohy needle

to demonstrate negative pressure upon entry of the epidural space. They describe this method as simple, dependable, inexpensive, and readily available.<sup>1</sup>