the best possible service. As a solution the combination of the principles of both Mapleson A (Lack or Magill) and Mapleson D (Bain) into one simple system would seem advantageous. Such a system has been described recently[8] and is likely to be available in the United States in the near future. The new system is simpler to operate than the Bain, is more versatile, uses low flow at all times, and allows easy scavenging. Hence, the convenience of the Bain system is no longer a valid reason for its continued use for spontaneous respiration.

D. HUMPHREY, M.B.B.S., D.A.
Lecturer
Department of Physiology
University of Natal
P.O. Box 17039
Congella 4013
Natal, Republic of South Africa

REFERENCES

1. Dean SE, Keenan RL: Spontaneous breathing with a T-piece circuit. ANESTHESIOLOGY 56:449–452, 1982
2. Dean SE, Keenan RL: Rebreathing and the Bain circuit, ANESTHESIOLOGY 58:393–394, 1983
3. Nott MR, Norman J: Rebreathing and the Bain circuit. ANESTHESIOLOGY 58:392–393, 1983
4. Humphrey D: The Lack, Magill and Bain anaesthetic breathing systems. J R Soc Med 75:513–524, 1982
5. Kain ML, Nunn JF: Fresh gas economics of the Magill circuit, ANESTHESIOLOGY 29:964–974, 1968
6. Flynn PJ, Morris LE: Humidity in anaesthetic systems. Br J Anaesth 53:1096, 1981
7. Chalon J, Patel C, Ali M, Ramanathan S, Capan L, Tang C, Turndorf H: Humidity and the anaesthetized patient. ANESTHESIOLOGY 50:195–198, 1979
8. Humphrey D: A new anaesthetic breathing system combining Mapleson A, D and E principles: A simple apparatus for low flow universal use without carbon dioxide absorption. Anaesthesia 38:361–372, 1983

(Accepted for publication July 7, 1983.)

Anesthesiology
60:81, 1984

Rebreathing and the Bain Circuit. II.

To the Editor:—The original article[1] and subsequent correspondence[2,3] on carbon dioxide tensions in inspired anaesthetic gases prompt me to ask what the presently accepted level of carbon dioxide is in fresh air?

According to my copy of the *Handbook of Chemistry and Physics,*[4] dry atmospheric air contains 0.033 ± 0.001% of carbon dioxide by volume. (P_{CO_2} 0.25 mm STPD). However, popular press reports on the "green-house effect" suggest that this level is rising.

It would seem logical to consider any concentration of carbon dioxide in the inhaled atmosphere which is in excess of that in fresh air to be unphysiological, and to constitute a threat to the homeostasis of the patient's *milieu intérieur.*

Is the presently available monitoring equipment as sensitive and as accurate as the human respiratory centre? Would our patients not be safer if we used non-rebreathing techniques to avoid altogether the potential hazard of re-breathing carbon dioxide?

DR. C. STANLEY JONES
P.O. Box 569
314 Sanlam Building
Stockenstrom Street
Worcester, CP 6850
Republic of South Africa

REFERENCES

1. Dean SE, Keenan RL: Spontaneous breathing with a T-piece Circuit. ANESTHESIOLOGY 56:449–452, 1982
2. Nott MR, Norman J: Rebreathing and the Bain circuit. ANESTHESIOLOGY 58:392–393, 1983
3. Dean SE, Keenan RL: Rebreathing and the Bain circuit. ANESTHESIOLOGY 58:393, 1983
4. Weast RC: Handbook of Chemistry and Physics, 59th Edition. West Palm Beach, CRC Press, 1978–1979

(Accepted for publication July 7, 1983.)

Anesthesiology
60:81–82, 1984

A Simplified Method of External Jugular Vein Cannulation

To the Editor:—We currently use a simple technique for cannulating the external jugular vein (EJV) for central pressure monitoring that obviates the need for a "skin nick" with a #11 scalpel blade, hence the risk of lacerating the EJV.

The technique is as follows: the EJV is cannulated with an 18 g or 16 g Medicut® catheter over needle that has a stiff and widely tapering hub on the catheter. Once the vein has been identified, the catheter can be advanced with firm pressure and a slight twisting motion, using the

tapered hub basically as a dilator of the skin and subcutaneous tissue, to the end of the hub if desired. The wire then can be placed in the usual manner, followed by the central venous catheter that now can be placed over the wire without the skin cut, thus avoiding injury to the vein with the blade but still having good tissue dissection for facilitation of catheter placement.

Our use of the Medicut® catheter technique for EJV cannulation has been highly successful with all our anesthesia personnel, including staff as well as residents and nurse anesthetist trainees.

DOUGLAS D. LEE, M.D.
Chief Resident

JULIAN S. CHESTNUT, CDR, MC
Assistant Chairman

Department of Anesthesiology
Naval Hospital San Diego
San Diego, California 92134

(Accepted for publication July 7, 1983).

Anesthesiology
60:82, 1984

Continuous Pharyngeal Suction during Surgery

To the Editor:—During a 5-year period, from 1977 to 1982, 450 patients had an upper gastrointestinal anastomosis performed in the Soroka Medical Center, the majority of which being gastric bypass operations for morbid obesity.

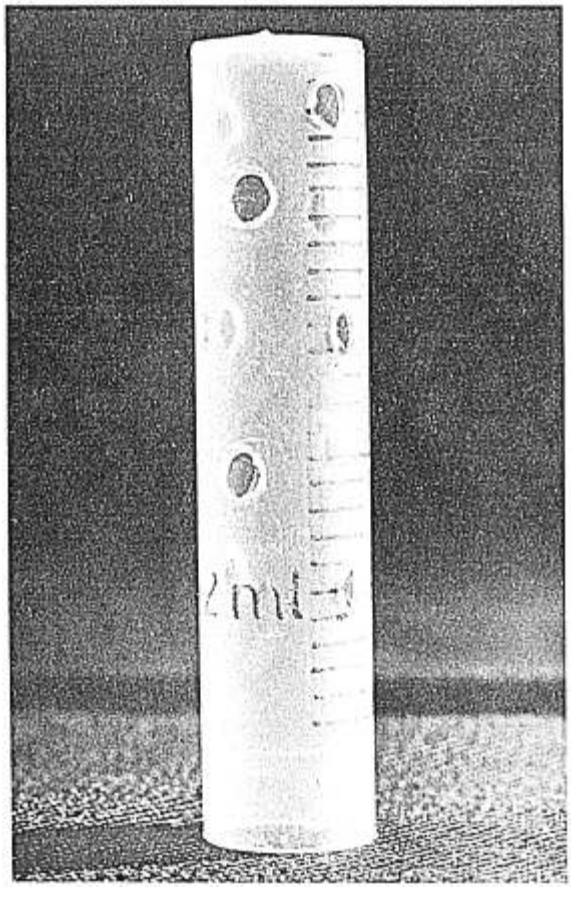

FIG. 1. The modified syringe adjusted as a suctioning device.

The use of methylene blue to test the integrity of the completed anastomosis is a routine measure that has justified itself more than once by revealing leaks of minor magnitude. An untoward side effect is that the filling of the anastomosis with the dye is often followed by an overflow of the dye into the mouth, causing considerable staining of the patient's face and hair, as well as anesthetic equipment and sheets.

In order to avoid this side effect, a continuous suction device has been used. A 2-ml disposable plastic syringe is used. The internal part of the syringe is removed and the tip to which the needle is attached normally is cut off. Then 8–12 holes are drilled circularly around the body of the syringe (fig. 1). This device is connected to the tube leading to the suction machine. It is introduced into the oropharynx and held there during the entire operation.

The immediate result of the use of this device was that there were no events of overflow of dye into the mouth, and the patients no more suffered the embarrassment of the resulting discoloration of their faces and hair. The anesthesiologists no longer complain about the inevitable staining of their equipment and hands. The members of the nursing staff also have changed their negative attitude toward this test.

LEV GREEMBERG, M.D.
AMNON OVNAT, M.D.
JOCHANAN PEISER, M.D.
ILAN CHARUZI, M.D.
THOMAS GESZTES, M.D.
Departments of Anesthesiology and Surgery "C"
Soroka University Hospital and Faculty of Health Sciences
Ben-Gurion University of the Negev
Beer-Sheva, Israel

(Accepted for publication June 21, 1983.)