Head and Chin Cushioned Face-rest for Surgery in the Prone Position

To the Editor—When patients are placed face down for surgical procedures, optimal positioning of the head and neck may be difficult to achieve. Rotating the head to one side may be poorly tolerated by some patients. A new cushioned face-rest device with disposable, inert foam plastic cushions mounted on adjustable forehead and chin rest platforms has been developed.¹ The device is placed on the face, adjusted as to facial size and anticipated chin-forehead angulation, and held in place during transfer from the litter to the operating table by a standard, perforated rubber mask strap. The strap is removed after the patient is rotated onto the table, and the head remains free during the surgical procedure. The elevation of the chin relative to the forehead (and table surface) is readjusted to achieve a neutral position for the neck. The unit may be placed almost anywhere along the surface of the operating table, covered or bare. The chest must be elevated above the plane of the table by about 25 cm, which permits the neck to fall slightly forward and, thus, assume a normal, slightly lordotic position. The device was designed to be used with a prone-sitting (kneeling) frame primarily for posterior spinal surgery.² It has been used in over 100 cases to date and has proven to be an improvement over a simple face pillow or cushion used with the head turned to the side.

Figure 1 shows the patient lying on the shoulder cushions and the new face-rest unit. Note the separate chin and forehead cushions. The distance between these is adjustable, as is the angle of the chin rest. Note also that the anesthetic tubing, etc., passes out through the space between support rods. The face is almost fully accessible.

Charles D. Ray, M.D., F.A.C.S.
Associate Director
Institute for Low Back Care
2737 Chicago Avenue
Minneapolis, MN 55407

REFERENCES

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ECG Monitoring with an Advanced, Truly Portable Electrocardioscope

To the Editor—Common practice when administering regional anesthesia is the prior placement of an intravenous catheter and various forms of monitoring, including the electrocardioscope. Because of inconvenience, this is rarely done during the placement of epidural anesthesia for labor and delivery.

For the same reason, the admonition to test-dose epidural catheters with epinephrine (15 μg or 3 ml of a 1:200,000 solution) to detect intravenous injection has been difficult to incorporate into clinical practice. Yet, the "epinephrine response" with inadvertent intravenous catheter placement may be difficult for the patient to detect and describe. Physiological changes may be of such limited magnitude and duration that continuous ECG monitoring is required, as suggested by Moore and Batra.¹

We have found a solution to these requirements in utilizing a truly portable ECG, the Microcor® monitor.* It

* Microcor®, 434 Lawndale Drive, Salt Lake City, UT 84115.
is battery-operated, compact (9½”l, 4”w, 2”d), and lightweight (1.6 lbs). Easily stored on block carts, it can even be carried in a jacket pocket. (Comparable “portable” monitors are 10 times as heavy and three times as expensive!)

Our preference in a busy obstetrical anesthesia practice is to insert the epidural catheter early in labor. Epinephrine testing with ECG monitoring is done at this time. The ECG electrodes remain in place for subsequent test dosing, while the monitor can be used with sequential patients.

Quick transfer can be made when a distressed infant is delivered. ECG monitoring is greatly superior to cord palpation during oral suctioning–endotracheal suctioning for meconium aspiration and resuscitation efforts. Hands are, thus, freed for measures other than pulse monitoring. Thus, arrhythmia monitoring is provided, which can easily be moved with the newborn from the delivery suite to the newborn care unit.

Other uses for this versatile monitor have quickly emerged. We have utilized the Microcor electrocardioscope as a second monitor for simultaneously observing anterior and inferior wall myocardial ischemia (the low frequency response is 0.05 Hz). Built-in electronic calipers allow for comparison, using the freeze-frame and memory features, in quantifying ST-segment changes.

PAUL J. DIEHL, M.D.
Staff Anesthesiologist
Cottonwood Hospital
Medical Center
Murray, UT 84107

EDWARD A. LOESER, M.D.
Chief of Anesthesiology
Cottonwood Hospital
Medical Center
Murray, UT 84107

Clinical Instructor
University of Utah
Medical Center
Salt Lake City, UT 84132

REFERENCE

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Another Method to Secure Drapes on IV Poles

To the Editor:—It is common practice during surgery to separate the operative field from the anesthetic area with the help of a screen. In some cases, this partition is created with the help of the ether screen and, in others, the drapes are hooked to the iv poles with the help of towel clips.

We have found easy use of a disposable horseshoe-shaped clamp adaptor from the PharamaCone Central Venous Pressure Monitor Kit (Cat. No. 4338A) (fig. 1). This semicircular plastic part snugly fits onto the ¾ in diameter pole. We use this part to secure the drapes instead of towel clips. The drapes stay at the same place and do not fall down, as it happens sometimes with towel clips.

We think this piece of information may be useful to others in the field of anesthesiology.

B. K. KATARIA, M.D.
Instructor in Anesthesia

J. CHEN, M.D.
Assistant Professor
Georgetown University Hospital
3800 Reservoir Road, N.W.
Washington, D. C. 20007

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