

### Mini-spike Dispensing Pin—An Efficient Way to Prepare Dantrolene

*To the Editor:*—Most anesthesiologists are familiar with the dispensing pin provided in thiopental kits. Recently,

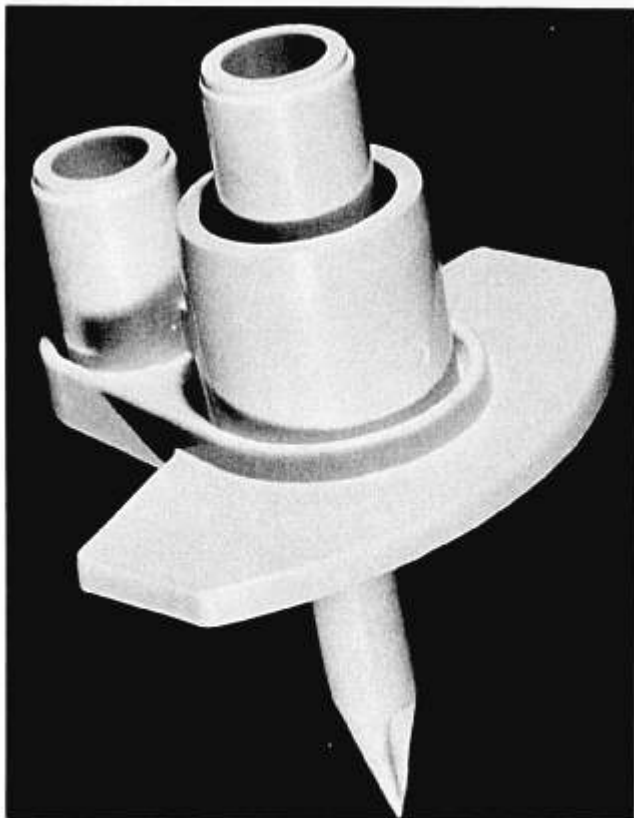


FIG. 1. Mini-spike dispensing pin.

we became aware of a similar device that allows for quick withdrawal of solutions in smaller vials.

A patient with a family history of malignant hyperthermia was to be pretreated with dantrolene. Her dosage requirement necessitated preparation of eight vials. Time needed to prepare the drug was greatly facilitated with the dispensing pin obtained through our pharmacy. A 0.45 micron filtered vent provides air displacement, allowing for rapid injection of diluent and transfer from vial to syringe *via* the luer connector.

We recommend that the dispensing pin be considered for use on emergency carts, particularly those designed to deal with malignant hyperthermia crises. Our supplier is Burron Medical, Inc., of Bethlehem, PA, and the list price for one pin is \$1.09 (fig. 1).

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### Subarachnoid Block: Two for the Price of One?

*To the Editor:*—Recently, following an uneventful spinal anesthetic for an inguinal hernia repair, a patient experienced a rather unusual neurological finding after being returned to his hospital ward.

The patient, a P.S. I, 59-yr-old man, underwent subarachnoid block with 75 mg of 5% xylocaine in 7.5% dextrose with 0.2 mg epinephrine utilizing a 25-G spinal nee-

dle placed at the L3-4 interspace. Placement was achieved without difficulty with the patient in the left lateral decubitus position. Clear CSF was obtained without blood or paresthesia. Surgery proceeded without problems, and the patient was discharged from the recovery room 2½ h later. Motor and sensory function was completely intact at that time. Within the next half hour, the patient began

to have some incisional pain, and, on turning to the right, lateral decubitus position to receive an intramuscular injection, he became "re-anesthetized." Within 2 min of turning onto his side, the patient developed a complete sensory block to about T12-L1 and a partial motor block in both extremities, the right being more profound than the left. The patient was completely oriented, and PE revealed no other abnormalities. These changes dissipated completely within an hour, and the patient was discharged the following day without further sequelae.

I am unsure of the mechanism of this phenomena, but, in light of the temporal relationship to change in position (the first change in position since the spinal was administered), one cannot help but speculate that there must

have been some additional hyperbaric xylocaine sequestered in a dural sleeve or loculation that, on changing position, was reintroduced into the CSF circulation.

I am unaware of any similar such phenomena in the literature, but, undoubtedly, there may be other clinicians who have encountered this problem before in their practice. Perhaps this case will help to remind us that there are no "routine" spinal anesthetics.

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### "Rose by any other name . . . But"

*To the Editor:*—I enjoyed reading the report by Watson *et al.*, "Clinically Significant Muscle Weakness Induced by Oral Dantrolene Sodium Prophylaxis for Malignant Hyperthermia," but, at the same time, I was disturbed by the use of the word "anesthesia" ("after consultation with anesthesia . . ."), instead of "anesthesiologist" or "anesthetist," in this article. I realize that it is a common practice in the United States to refer to the anesthesiologist as anesthesia, a terminology I have been trying to eradicate in our institution. We do not refer to the surgeons as surgery! In my opinion, the word anesthesia used as a noun is absolutely inappropriate, and an anesthesiologist writing it in an acclaimed international journal is unforgiving.

I am refraining from the controversy of the grammar of this word, as the reflections are those of one whose

knowledge of the English language is imperfect, in spite of supreme efforts.

However, may I make a plea through ANESTHESIOLOGY, to all anesthesiologists to discourage others in referring to us as "anesthesia," but, rather, as an Anesthesiologist or by our own proper name! Above all, we should not use it in our writing. Our Specialty must maintain a good image if it is to continue to keep its status on the same level as other branches of medicine.

I do not wish my comments to detract from the message of Wilson *et al.*'s excellent case report.

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### Bronchial Cuff Pressure: Comparison of Carlens and Polyvinylchloride (PVC) Double Lumen Tubes

*To the Editor:*—Rupture of the main bronchus and the concomitant use of double lumen tubes have been reported. Excessive pressure after over-inflation of the bronchial cuff may play a role in the bronchial damage during the use of red rubber double lumen tubes.<sup>1-3</sup> Besides easier placement, the polyvinylchloride (PVC) tubes

are built with low pressure cuffs that can decrease the risk of bronchial rupture, although such a case has already been described.<sup>4</sup>

We recorded the bronchial cuff pressures of 50 patients intubated with left PVC double lumen tubes (n = 24) and with left Carlens tubes (n = 26) to determine the safer