

use of electrocautery in close proximity to PVC endotracheal tubes, as suggested by Simpson and Wolf, we feel the use of N₂O and O₂ during anesthesia for intraoral, pharyngeal, or laryngotracheal procedures should be avoided completely in favor of air or air-oxygen mixtures.

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Anesthesiology
66:448, 1987

In Reply:—We agree with Shapiro and El-Baz that “the use of N₂O and O₂ during anesthesia for intraoral, pharyngeal, or laryngotracheal procedures should be avoided completely in favor of air or air-oxygen mixtures” only with the proviso that electrocautery and/or laser is required for surgery. Certainly, the combination of a fuel (endotracheal tube), an oxidant (oxygen and/or nitrous oxide), and an ignition source (electrocautery or laser) has the potential for fire. When any one of the triad is missing, however, fire is unlikely.

Anesthesiology
66:448-449, 1987

Malignant Hyperthermia: Are We Really Prepared?

To the Editor:—Malignant Hyperthermia remains a formidable challenge to anesthesiologists. As with so many other nightmarish situations in medicine, being prepared is the key to successful management. Dantrolene, the drug of choice, when used appropriately,¹ has contributed to the reduction in mortality from 90% to about 10%. Since dantrolene is an emergency drug, experts agree that it should be immediately available at all anesthetizing locations. That means, in most cases, in the operating room.²⁻⁵

Recently, we conducted an informal telephone survey of all hospitals and surgical centers in Dallas, Texas, as listed in the Parkland Memorial Hospital telephone directory. Twenty-three institutions at which surgical procedures under general anesthesia are performed were polled. All major hospitals had dantrolene available within the operating room.

However, four of 23 surgical locations had no dantrolene available in the hospital. One further institution stored dantrolene in the pharmacy, but not in the operating room.

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(Accepted for publication November 18, 1986.)

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(Accepted for publication November 18, 1986.)

We are of the opinion that, in the management of a malignant hyperthermia crisis, every minute counts. Storing dantrolene in the operating room should be as mandatory as storing, for example, epinephrine and other resuscitation drugs and devices.

Anesthesiologists should not rest until mortality from malignant hyperthermia is completely erased. To reach that goal, we need to be prepared, wherever we practice.

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(Accepted for publication November 19, 1986.)

A Simpler Tidy Adjunct to Arterial Cannulation

To the Editor:—I read with interest the recent letter "A Tidy Adjunct to Arterial Cannulation."¹ I routinely use a similar technique that is even easier.

Provided with each intravenous (or intraarterial) catheter is a transparent plastic shield, designed to protect the needle-catheter assembly during shipment. The shield is hollow, and has a hole in its distal end. Before attempting an arterial puncture, after the plastic plug is removed from the needle, the shield is attached to the proximal end of the needle instead of being discarded (fig. 1). Backflow indicating arterial puncture is then observed inside the shield. From 1-3 cc of backflow can be held in the shield, depending on the type of catheter used.

This technique is equally as "tidy" as the one previously reported. It also is faster and easier to do, and allows you to keep your syringe, already filled with local anesthetic, available for further use.

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Anesthesiology
66:449-450, 1987

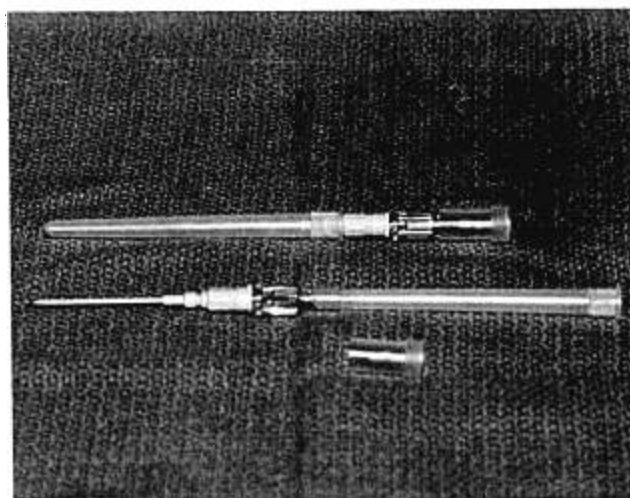


FIG. 1. Catheter and shield before and after re-assembly.

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(Accepted for publication November 23, 1986.)

Prevention of Leak of Local Anesthetic from Under a Pneumatic Tourniquet

To the Editor:—Grice's¹ investigation of the mechanism of anesthetic leakage under a tourniquet during intravenous regional anesthesia deserves the highest congratulations for clearly defining the source of an occasional life-threatening complication during a generally safe and well-accepted anesthetic technique. One needs only to avoid injecting the local anesthetic at pressures higher than the effective tourniquet pressure. But how can this be done? The authors suggest that injection should be slowed to take at least 90 seconds. This is, however, an indirect way of limiting injection pressure. A much more direct way exists.

DLP Inc. (620 Watson S.W., Grand Rapids, MI 49501-0409) manufactures a "Pressure Sensing Syringe," currently used for distending harvested veins during coronary bypass grafting. This syringe incorporates a tactile feedback sensor which allows the user to avoid exceeding 250 mmHg when distending the vein graft. The company indicates that the syringe can be recalibrated during manufacturing with an upper limit of 170 mmHg, which would allow direct control over the pressure of injection during intravenous regional anesthesia, thereby totally preventing local anesthetic from gaining access to the systemic circulation while the tourniquet is inflated. By using this