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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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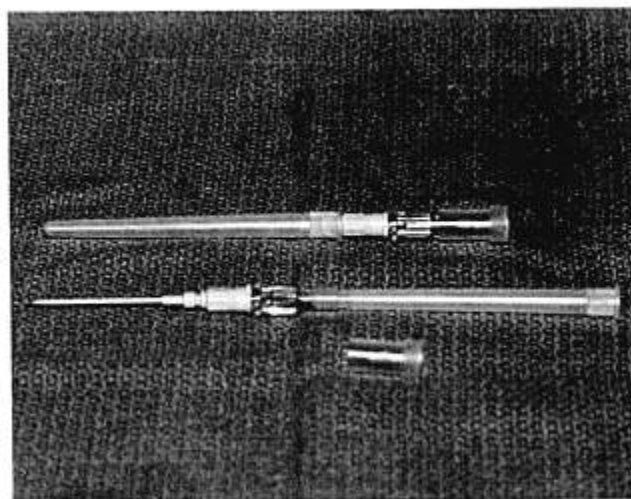


FIG. 1. Catheter and shield before and after re-assembly.

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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