

## CORRESPONDENCE

into possible mechanisms of anesthetic-induced vasodilation. On the other hand, we used a method of administration in which isoflurane concentrations were changed over minutes (not seconds) and which is more akin to the clinical use of isoflurane. Thus, under conditions similar to those occurring clinically, we would characterize isoflurane as a mild dose-dependent vasodilator.

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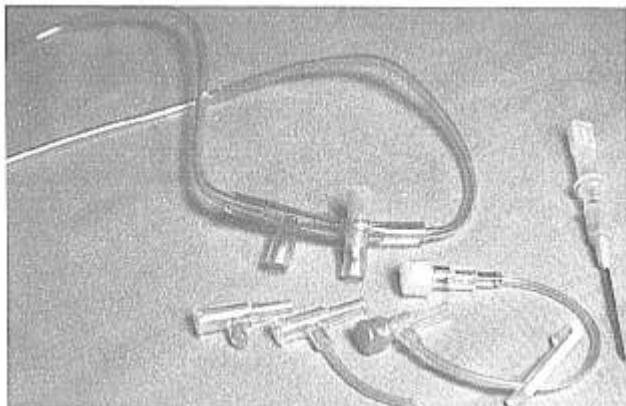
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## Measurement of Carbon Dioxide at Both Nares and Mouth Using Standard Nasal Cannula

*To the Editor:*—The nasal cannula commonly serves a dual purpose in the setting of monitored anesthetic care. In addition to allowing the delivery of supplemental oxygen, the cannula can be used as a carbon dioxide sampling site for the monitoring of respiratory rate and rhythm.

When asleep or sedated, many patients breathe orally. While these patients continue to receive the benefits of supplemental oxygen because of the entrainment of oxygen from the nasopharynx, expired carbon dioxide is not measured at the nares. Commercially produced



**Fig. 1. Required equipment.**



**Fig. 2. Equipment in place.**

nasal cannulas offer the ability to measure carbon dioxide at both the nares and the mouth, but these cannulas may not be readily available or cost-effective.

Taking a standard nasal cannula, a 14- or 16-G angiocatheter, and pediatric "T-piece" intravenous tubing, we fabricated a simple device to measure nasal and oral carbon dioxide. After removing the catheter from the needle, it is cut off the hub and replaced onto the needle. This needle assembly is inserted into the nasal cannula as shown in figure 1, and the needle is removed, leaving the hub in place. The rubber end is removed from the pediatric T-tubing and the carbon

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dioxide sampling tubing is connected at this site. The male site of the T-tubing is connected to the angiocatheter hub. The remaining length of T-tubing can be customized to the optimal length for each patient, as shown in figure 2.

We have found this device to be simple to prepare, inexpensive and reliable.

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## Global Department of Anesthesiology Formed

*To the Editor:*—Last year, Ruskin and Tissot described an Internet listserv dedicated to the promotion and discussion of anesthesia.<sup>1</sup> Primarily for anesthesiologists, this list is joined by CRNAs, anesthesia technicians, and researchers. As of April 1994, this list had 320 members. Although Sopchak also had created a list,<sup>2</sup> the Ruskin-Tissot list was the first list cited in anesthesiology literature. Both of these lists enjoy success. This medium provides a worldwide informal dialog among anesthesia professionals.

As an example of the value of participating, we would like to present a synopsis of 1 month's messages. An examination of the anesthesiology list dialog of March 1994† revealed 207 messages contributed. These messages addressed 28 topics, e.g., premedication of children, spinal morphine following spinal surgery, cost savings, and partner in operating room during cesarean section. Represented in these discussions were the following countries: Australia, Canada, New Zealand, South Africa, United States, and several participants from European countries. A request for comments from a representative of the Food and Drug Administration regarding neurotoxicity of 5% lidocaine elicited six responses.‡

The potential of this method of communication to have an impact on modern anesthesiology is relatively untapped. Private practice physicians can join their academic counterparts for consultation and dialog. Responses from other caregivers, both academic and private, can add a new source for consultation in a difficult case. Subscription, for those with access to the Internet, is free. Individuals who do not have access to the Internet can subscribe to the list *via* popular and widely available on-line services such as CompuServe and America

On-Line. The list is open to anyone who wishes to subscribe. There is discussion about making subscription "limited" to preserve the professional nature of the discussion list. Individuals have expressed concern about being inundated with irrelevant mail. Current traffic is averaging four messages per day on the anesthesiology list. If this increased to unmanageable levels, "moderated" sublists could be created, meaning that a moderator would check all messages before distribution on the network.

We encourage readers to investigate for themselves the value of this new communication method as an instrument of ongoing and wide-ranging medical education that is not excessively time-consuming.

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† Anesthesiology Discussion Group Digest [Online]. Available FTP: gasnet.med.nyu.edu Directory: pub/anes/digests File: 94-03.txt.

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