CORRESPONDENCE

TEACHING OF GENERAL ANAESTHESIA FOR DENTAL SURGEONS

Sir,—At the recent Annual General Meeting of the Australian Society of Anaesthetists, members discussed the Editorial in the May issue of the Journal (Brit. J. Anaesth., 1964, 36, 267).

As a result of this discussion, the Society wishes to record that it strongly deprecates the opinion expressed in the Editorial.

We appreciate the fact that the circumstances in the United Kingdom are different from those in Australia, but it is our view that it is the duty of all trained anaesthetists to strive for ideal conditions for dental anaesthesia.

We feel that full use should be made of local anaesthesia in dentistry, and that, where general anaesthesia is absolutely necessary, two persons should be present.

Furthermore, we consider that the anaesthetic should be administered by a medical practitioner, preferably a trained anaesthetist.

Similar views to these have been expressed in the past by the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

P. A. MAPLESTONE, Hon. Sec., Australian Society of Anaesthetists

CROSS-INFECTION DURING ANAESTHESIA


Unlike the surgeon, who uses nothing but sterile tools and aseptic technique, the anaesthetist requires some of his instruments to be sterile, but others to be only clean; and he must handle patients who, though generally socially clean, are certainly not bacteriologically so. The anaesthetic room nurse, if for this reason alone, often requires more intelligence and understanding than does the scrub nurse.

I stress four points to help her.

(1) The patient's tissues, bloodstream and trachea are normally sterile—only sterile instruments must be used in these parts.

(2) Unlike the normally sterile trachea, which is lined with a relatively delicate, two-layered, ciliated epithelium, the mouth and lower pharynx are always full of bacteria, and have a thick, stratified, protective epithelium designed to withstand wear-and-tear—such as hot steak and chips! Instruments for use in the mouth need, therefore, only be as clean as one's spoon and fork at table.

(3) Instruments with reasonably smooth surfaces are rendered nearly sterile by thorough scrubbing with soap and hot water; this treatment is, therefore, satisfactory for laryngoscope blades, facepieces, airways, etc., and does not cause them to deteriorate. Endotracheal tubes, and all intravenous equipment should be sterilized, and thereafter handled only with "no touch" technique—e.g. endotracheal tubes are held only by the metal connector.

(4) I reserve the top shelf of the Boyle's machine for clean things; contaminated things go into a receiver on the bottom shelf, remembering that used syringes and needles should be kept separate from such heavily contaminated articles as airways.

Of course, when particularly heavy contaminations arise, as for instance from cases with acute respiratory infections or open T.B., or when the patient is a special risk, such as a neonate, special precautions must be taken. But in general the teaching outlined above enables a satisfactory, and easily practicable standard to be maintained by the anaesthetic team.

J. C. AINLEY-WALKER
Kent

DEFECTS IN ENDOTRACHEAL TUBES

Sir,—Stimulated by the amount of space devoted to problems associated with intubation in your last issue, I am prompted to make a postscript to my own small contribution in this field.

The manufacturers of cuffed rubber tubes recommend they should be either boiled or autoclaved, but to combine the processes will cause rapid deterioration of the rubber with any given tube. One of my senior colleagues, Dr. R. J. F. Moore, recently found a tube with two weaknesses side by side on the cuff. This was puzzling at first as one could be explained by overinflation. But why two?

The Theatre Superintendent, Miss E. M. Walker, solved the mystery by pointing out that the two defects matched exactly the holes on the side of the metal trays used in autoclaving. The high vacuum pressure employed was obviously responsible.

Incidentally, the practice in this hospital is to pack the tubes separately in paper bags prior to sterilization. It is probably rather a coincidence that a tube should lie in such a position, but then how many anaesthetists prepare a tray of equipment prior to autoclaving!

M. M. CLARK
Burton-on-Trent

COMBINED T-PIECE AND NON-REBREATHING VALVE


Instead of:

It should be:

SHAOTSU LEE,
Morgantown