ZUSAMMENFASSUNG

INYECCION INTRAARTERIAL DE ANFETAMINA: UN INSOLITO RIESGO DE LA APLICACION DE DROGAS
Se describe un caso de inyección de una solución de sulfato de anfetamina en la arteria radial. El tratamiento, que fue iniciado tan pronto como se pudo, consistió en un bloqueo simpático y administración de vasodilatadores, heparina y antibióticos. Con el aumento del número de drogas administradas, este síndrome puede presentarse más frecuentemente.

CORRESPONDENCE
TWO ANCILLARY DEVICES FOR USE WITH A PIPED-GAS SYSTEM
Sir,—In the operating suite of most hospitals which have a piped supply of oxygen and nitrous oxide, it is customary for outlets (pendants or wall-mounted) to be sited both in the anaesthetic room and in the operating theatre. Casual observation suggests that anaesthetists are equally divided in the choice of how to deal with the problems associated with the transfer of the patient from the anaesthetic room to the theatre:
(a) The piping may be disconnected at the Schroder link subsequent to induction of anaesthesia, and after a hurried removal to the theatre, a connection is made between the anaesthetic machine and the theatre pendant.
(b) Long pieces of tubing are installed between the machine and the outlets, and the machine is "fed" from the anaesthetic room outlet until an exchange can be made.
(c) Similar to (b) but no exchange is made.
Of these alternatives, (a) has little appeal, even under the circumstance—occasionally in operation—that use is made of an oxygen cylinder on the machine to ensure adequate oxygenation during transfer. In emergency cases, and especially when the patient is at high-risk, there is a possibility that a disaster could occur as a result of failure to reconnect the piped gas supply promptly. The other two methods require tubing extending from within the theatre to the anaesthetic room. This may be an obstacle to the movement of equipment within the theatre and may be a hazard to personnel.

Left: As attached to the anaesthetic machine in the anaesthetic room. The enamelled coat of the cover of the drum labelled N₂O is coloured the appropriate shade of blue, with white lettering; the O₂ drum-cover is white with black lettering.
Right: The assembly folded against the wall whilst not in use.
Recently we have devised and introduced to the Birmingham Maternity Hospital a retractable hose-reel which virtually eliminates these dangers and inconveniences.

Accidental dropping of the male connection (key and plug) of the Schrader link may distort the soft metal of which it is made and we now use a "safety-ball" device for preventing this.

The retractable hose-reel (fig. 1).

This is a self-retracting, spring-loaded, hose-reel containing 20 feet (6.1 m) of one-quarter inch (6.3 mm) bore plastic, braided, antistatic hose and fittings as supplied by British Oxygen Company Ltd, for piped-gas systems. The oxygen or nitrous oxide is fed by a short length of conventional tubing from the supply point (pendant or wall-mounted) into the tubing contained within the hose-reel by means of a (non-interchangeable) Schrader coupler. The latter leads to the end of the main spindle which carries the reeling drum. The spindle has a hole drilled part way through it and connects with a hose fitting to which the hose itself is joined. The hose is wound around the reeling drum, and the outlet end is passed through a hose guide containing four nylon rollers. A rubber ball which it is made and we now use a "safety-ball" device to avoid the hose and anaesthetic machine being under constant tension during use. It can be released—to permit retraction—by pulling the hose out a further 6–12 inches. The main covers are fitted with a small dome which houses the main spring and is sealed to avoid leakage of oil or grease. The design permits easy access to the whole unit for servicing, and the main spring can be exposed for replacement, or for adjustment of tension, by the removal of three small bolts. The whole hose assembly can be withdrawn with ease after removal of the front cover.

The provision of a wall-bracket allows the whole unit to be folded flat against the wall when the apparatus is not in use. The bracket is so designed that the hose-reel can be lifted off it without recourse to screwdriver or spanner.

The rubber "safety-ball" (fig. 2).

This is 2 inches (5.1 cm) in diameter, with a half-inch (1.3 cm) hole through the centre, and made of antistatic quality rubber. A hose ferrule is required with each ball. It is fitted as follows: the hose is pushed through the ball for a distance of about 12 inches, and the ferrule is placed loosely over the end of the hose. The appropriate (male or female) component of the Schrader link is inserted tightly into the end of the hose and the ferrule is then pinched tightly on to the hose, using a Crimping Tool (preferably four crimps). Finally, the ball is threaded along the hose until the ferrule lies within it.

At the time of writing, the hose-reel has been in operation in our hospital for 4 months, and has proved to be very acceptable. The only adverse comment regarding its usage is that because of the strong spring, the tubing achieves quite a high velocity if it is allowed to retract without restraint, and to avoid repeated damage to the wall beneath the brackets, we have applied a protective square of plastic to the appropriate site. There is no explosion hazard associated with the use of this device.

The hose-reel was designed by Mr D. H. Pritchard of J. A. R. Developments (G.E.) Ltd, 174 Kings Road, Tyseley, Birmingham, B11 2AR (Managing Director, Mr M. L. Houchin). The hose-reel is manufactured by this Company, which also supplies the rubber "safety-balls". Thanks are due to Mr W. H. Biffen, Instrument Curator, Queen Elizabeth Medical Centre, for help in the organization of the equipment, to the anaesthetists, to Mr H. L. Jones (Theatre Attendant) and other members of the Theatre Staff for putting it to the test.

J. SELWYN CRAWFORD
Birmingham

A LITTLE LEARNING

Sir,—Thank you for the April 1973 editorial entitled "A Little Learning". I agree with the views expressed on the variability of current undergraduate anaesthetic teaching. A survey conducted in Aberdeen has revealed that in eighteen British Universities the total number of hours spent on undergraduate training in anaesthetics and resuscitation ranged from 24 to 200 hours. There would appear to be a need for a more uniform approach to the subject.

In the past the General Medical Council has stated that anaesthetics has no place in undergraduate education. Many anaesthetists agree with this policy but concern was expressed at the Annual Meeting of the Association of Anaesthetists held in London (1972) at the shortage of anaesthetists in the junior registrar grade. Could this problem be solved by anaesthetists pressing for a greater share of the undergraduates' study time? In 1966 a survey conducted on sixth-year medical students revealed that 2% favoured anaesthetics as a career (Parkhouse, 1972). This is a disturbingly low figure when the excellent career prospects in anaesthetics are considered. Perhaps good quality candidates could be recruited into the specialty if they are shown at an early stage in their undergraduate training how anaesthetists dovetail into many aspects of surgical, medical and obstetrical practice. The undergraduate should be aware of the anaesthetist's contribution to the intensive care unit, pain clinic, maternity epidural services and anaesthetic out-patient clinics. Furthermore, the practical activities of vepen puncture, airway maintenance, endotracheal intubation and monitoring should play a part in any young doctor's education. In addition, there should be more co-ordination in the medical curricula with anaesthetics integrating with teaching in human physiology and clinical pharmacology.

I am aware that the views expressed in this letter are not universally held. However, the findings of the one-day Seminar on "Undergraduate Teaching in Anaesthetics" on June 5 will be awaited eagerly.

T. W. OGG
Aberdeen

REFERENCE


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