trachea than an endotracheal tube, because of its narrow diameter and relative stiffness.

Although other materials have been used as a guiding stylet, the technique we describe has distinctive advantages over others. By using the suction catheter readily available in every operating room and almost always needed in such cases to clear the airway, the oropharynx can be cleared under direct vision and, immediately thereafter, the suction catheter can be inserted into the trachea without distracting visual attention. Then the catheter can be used as a guiding stylet as others have done.

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REFERENCES


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Pollution Associated with Keyed Filling Devices

To the Editor:—Prevention of pollution of operating theatres by volatile anesthetics associated with the filling of vaporizers, as described by Williams et al., is a daily problem. What is not clear from Williams et al. is whether the filling device was separated from the bottle of liquid anesthetic (after filling the vaporizer) or if the filler and bottle remained attached.

If the two were separated, then the solution is quite straightforward. We found, some years ago, that, if filling devices are not removed from the bottles of liquid anesthetic between vaporizer fillings, then operating room pollution is reduced dramatically. Using this method, the only time pollution occurs is when a bottle is first uncapped and the filling device attached. Since the keyed filler is removed only when bottles are empty, no spillage occurs. Leaving the filling devices in situ does not lead to pollution, since leakage is negligible if bottles rest undisturbed. Further advantages of leaving the filling devices in place are that damage to fillers and the possibility of error and cross contamination among the various anesthetic liquids is reduced.

If, on the other hand, the bottle and filler were kept attached and then placed in the anesthetic machine drawer for storage, then we suggest that movement of the drawer and machine agitated the liquid anesthetic in the bottles, leading to increased loss by vaporization.

Fig. 1. Argyle Aero-Flo™ suction catheter used as a guiding stylet.

Oropharynx is suctioned of copious secretions and blood that frequently obscure vision after multiple intubation attempts. The catheter tip was then advanced into the trachea. The Aero-Flo™ Tip suction apparatus was removed and the suction catheter was used as a stylet over which the endotracheal tube was advanced (fig. 1). The suction catheter was more easily maneuvered into the oropharynx than suctioned of copious secretions and blood that frequently obscure vision after multiple intubation attempts. The catheter tip was then advanced into the trachea. The Aero-Flo™ Tip suction apparatus was removed and the suction catheter was used as a stylet over which the endotracheal tube was advanced (fig. 1). The suction catheter was more easily maneuvered into the oropharynx than

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In Reply.—We apologize for having missed the article by Davies et al.1 in our literature search. In it, there is an explanation of the two peaks in our graph of vapor concentration.2

We did, in fact, remove the filling device from the bottle, replaced the screw-top on the bottle, and then placed the filling device in a drawer in the anesthesia machine. Although Davies et al.1 showed that leaving the filling device in situ leads to negligible pollution if the bottles are at rest, our practice is such that the anesthesia machines and other potential resting places for bottles are frequently moved so that there is potential for spillage and, hence, even greater pollution from the vapor.

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Continuous Monitoring of Intracuff Pressures in Endotracheal Tubes

To the Editor:—The relationship between high intracuff pressures in endotracheal tubes to tracheal wall pressure and to tracheal ischemic injury has been well documented.1–3 The contributions of inspired oxygen and nitrous oxide (N2O) to cuff gas volumes over time have also been well documented.4–7

With automated oscillometric or intra-arterial blood pressure monitoring during surgery, the sphygmomanometer gauge mounted on most anesthesia machine consoles becomes an unnecessary option. This unused sphygmomanometer can provide a simple method for continuous intracuff gas pressure monitoring during long operative procedures (fig. 1).

A double male-ended rubber hose will connect the sphygmomanometer gauge to the pilot balloon of a cuffed endotracheal tube (fig. 1). The sphygmomanometer gauge will then display intracuff pressure. A three-way stopcock may be inserted somewhere along the rubber hose to allow for syringe deflation of excessive intracuff gas volumes when intracuff gas pressures exceed 18–25 mmHg. This simple technique will allow for continuous manometric monitoring of intracuff pres-

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