current anesthetic practices could be contributing to this global long-term problem.

By far, most anthropogenic N\textsubscript{2}O is released from the denitrification of agricultural fertilizers and the combustion of fossil fuels. It is estimated that these processes produce approximately $10 \times 10^{10}$ moles of N\textsubscript{2}O each year.\textsuperscript{1} While precise figures for the utilization of N\textsubscript{2}O as an anesthetic are not available, it is instructive to develop a rough estimate. If half of the 2.1 $\times 10^7$ surgical procedures performed yearly in the U. S. A.\textsuperscript{†} were each carried out with N\textsubscript{2}O flowing at 2 l/min for a duration of 2 h, this would result in the venting of $1.3 \times 10^8$ moles of N\textsubscript{2}O yearly. Considering that the number of anesthetics per capita worldwide is less than in the U. S. A. and the use of N\textsubscript{2}O is limited primarily to industrialized countries, the worldwide use of N\textsubscript{2}O may approximate five times that of the U. S. A. If so, total release of N\textsubscript{2}O to the atmosphere could be in the range of 0.5–1.0 $\times 10^9$ moles/year or less than 1% of the total global production of N\textsubscript{2}O.

While this figure seems to minimize the contribution of anesthesia to atmospheric N\textsubscript{2}O, we should not become complacent. Excessive atmospheric pollution could well disturb the delicate balance between N\textsubscript{2}O production and N\textsubscript{2}O absorption by natural geological and atmospheric “sinks.”\textsuperscript{1} Given the fact that N\textsubscript{2}O has an extremely long transit time in the atmosphere of over 100 years,\textsuperscript{1,2} future N\textsubscript{2}O emissions could have real impact.

\* Personal Communication. American Hospital Association, Chicago, IL.

REFERENCES


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A Simple Technique to Eliminate Needle Stick Injuries

To the Editor—Needle stick injuries are an occupational hazard for anesthesiologists. Most needle stick injuries occur when the needle is being recappped.\textsuperscript{*} Furthermore, the fluid in intravenous tubing should be considered contaminated because of possible previous backflow of blood.\textsuperscript{1} Any needle used to administer medicines into intravenous tubing should also be considered contaminated. The Center for Disease Control has recommended that forceps should be used to recap needles,\textsuperscript{2} but the naked, contaminated needle is still dangerous. We suggest the following technique to eliminate contaminated needles.

The anesthesiologist needs two designated areas in the operating room. A table in the operating room is usually designated the clean area. It is not to be touched by contaminated gloves, and is a distance away from the operative field or any contaminated substances. Needles are kept only on the clean area, and are for mixing

\* McCray E, Winslow N, Solomon SL, Martone WJ, Onorato IM, Munn VP: Prospective evaluation of health-care workers with parenteral or mucous-membrane exposure to blood from patients with acquired immunodeficiency syndrome. International Conference on AIDS, Atlanta, GA, April 14-17, 1985
Facilitating Difficult Tracheal Intubation

To the Editor:—Difficult tracheal intubation cannot always be predicted, and may occur when least expected. This usually results in a situation in which the practitioner tries numerous “tricks” and “techniques” to accomplish the intubation before abandoning various blades and stylets and resorting to more elaborate procedures. In addition, repeated laryngoscopy leads to fatigue. My approach has been to involve an assistant who can relieve me of some of the physical stress normally involved in this often frustrating experience.

The maneuver involves the placement of the laryngoscope blade in the optimum position and exposing the airway. An assistant (no training required) is then placed opposite the intubator and given the handle. With the guidance of the practitioner, the assistant is asked to retract on the handle. The practitioner is then able to use his left hand to manipulate the airway while advancing the endotracheal tube with his right hand. This allows optimum exposure of the airway while totally removing the physical strain of retracting with the laryngoscope.

This technique is also quite safe, as the handle of the scope is always retracted in a caudad direction, and prying or leveraging against the teeth is virtually impossible. The assistant must only be instructed to hold the handle in the position directed by the intubator.

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