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Video Induction: CO₂ Wars

To the Editor—To a child, the operating room is a bizarre place, full of strangers behind masks and replete with sinister-looking tools and machines. Distraction of the child, with stories, conversation, and games, has been a time-honored aid to inhalation induction in these circumstances.¹⁻³ One standard pediatric anesthesia text recommends that distraction techniques specifically avoid reference to the “equipment being used, breathing,” etc.⁴ As an alternative, we have chosen to practice distraction by focusing the child’s attention on the monitor. With the recent popularization of video games and personal computers, the monitoring screen has become a familiar object to most children. Using the context of the video game, this idea is incorporated into the preoperative visit. The child is given a mask for “practice” and is introduced to ECG patches. Most children then look forward to playing the video game in the operating room. The mask is given to the child, and the ECG connections are made. With the patient sitting, often in the anesthetist’s lap, a standard induction is pursued. Seeing the CO₂ trace on the screen, most children cooperate readily with the induction, especially since removing the mask makes the CO₂ trace fall (i.e., the patient loses “points”). Any number of variations on the game are possible; e.g., to make the CO₂ trace touch the ECG (Fig. 1), to use the numbers as points, or to set CO₂ limits so that alarms sound (that’s good in the video game context). Capnography has not only become a routine part of our anesthetic practice, but, in this use, it has helped to allay anxiety, increase cooperation, and speed induction in our pediatric population. Some of our patients have even asked to come back and play the game again!

Fig. 1. A young patient excitedly points out her CO₂ trace (Spacelabs Monitor 512D with Capnograph 540, Squibb Vitatek Inc., Hillsboro, OR).
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Magill’s Forceps

To the Editor:—The forceps used by Drs. Shah and Nossaman1 were originally used for guiding catheters, rather than endotracheal tubes, into the trachea, but were designed by Magill, not McGill. Sir Ivan Magill was a young man when he described them in 19202 as an aid to passing nasotracheal catheters for insufflation anesthesia. This was before he proceeded with the use of a single wide-bore tube for to-and-fro breathing.3

Magill celebrated his 90th birthday in 1978, at which time summaries of his publications over a period of 55 years were published.4

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Glottic Closure Following Large Doses of Fentanyl

To the Editor:—The inability to ventilate patients following large doses of fentanyl is ascribed to decreased thoracic wall compliance secondary to truncal rigidity.1

Recently, Scamman2 reported only minimally decreased compliance in patients with tracheostomies who received large doses of fentanyl (17 μg/kg), whereas the same dose in patients without tracheostomy resulted in failure to provide bag and mask ventilation, suggesting that the major problem is at the glottic level.

Concerned with the possibility of encountering ventilatory difficulty while administering large doses of fentanyl in patients presenting for cardiac surgery who, on preoperative examination, were thought to be possibly difficult to intubate, we performed fiberoptic laryngoscopy following adequate topical anesthesia utilizing a Patil-Syracuse mask and airway3 during anesthesia induction with large doses of fentanyl administered as an intravenous drip.

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FIG. 1. Open glottis but rigid trunk after large doses of fentanyl administered intravenously.