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REFERENCES


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Ear Wax and the Otolaryngologist

To the Editor:—I believe I have found one of the causes for the occasional breakdown in communication between the anesthesiologist and the surgeon. I have been asked to remove ear wax from the external ear canal of anesthesiologists on so many occasions that I have become convinced that this is an occupational hazard of their profession. It would seem that wearing the molded ear piece that connects to the stethoscope leads to a build-up of ear wax in the same manner that we see in some patients who wear hearing aids. This ear wax tends to be hard wax that is firmly impacted deep in the external ear canal.

Any anesthesiologist who notes unilateral decrease in hearing or ear discomfort probably has ear wax build-up and should consult an otolaryngologist to get the ear wax removed.

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Comparing Direct and Indirect Arterial Blood Pressures

To the Editor:—I recently completed a study similar to that reported by Nyström et al.,¹ comparing direct radial artery blood pressure with indirect brachial pressure by Dinamap 1846 Vital Signs Monitor®. This study differed from Nyström’s in two important respects. Measurements were made simultaneously rather than in series by using

<table>
<thead>
<tr>
<th>Range (mmHg)</th>
<th>Systolic</th>
<th>Diastolic</th>
<th>Mean</th>
</tr>
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<tbody>
<tr>
<td>≤50</td>
<td></td>
<td>−16.6 ± 1.4* (62)</td>
<td></td>
</tr>
<tr>
<td>61–80</td>
<td></td>
<td>−5.5 ± 0.5* (312)</td>
<td></td>
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<tr>
<td>81–100</td>
<td></td>
<td>−4.3 ± 0.8* (160)</td>
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<tr>
<td>101–120</td>
<td>−0.8 ± 3.7 (10)</td>
<td>−5.0 ± 1.4* (24)</td>
<td></td>
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<tr>
<td>121–140</td>
<td>2.9 ± 1.4* (64)</td>
<td></td>
<td></td>
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<tr>
<td>141–160</td>
<td>12.6 ± 0.9* (144)</td>
<td></td>
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<tr>
<td>161–180</td>
<td>20.0 ± 0.9* (145)</td>
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<tr>
<td>181–200</td>
<td>22.0 ± 0.9* (103)</td>
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</tr>
<tr>
<td>201–220</td>
<td>30.2 ± 1.9* (55)</td>
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<tr>
<td>221–240</td>
<td>40.2 ± 4.9* (22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>241–260</td>
<td>53.3 ± 4.8* (13)</td>
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<tr>
<td>≥261</td>
<td>72.5 ± 12.5 (2)</td>
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</tr>
</tbody>
</table>

Mean ± SEM, number of comparisons in parentheses. * Significantly different by paired t test (P < 0.001).

Table 1. Intraarterial Minus Dinamap® Blood Pressure
both arms after determining that blood pressure was similar in the arms measured by Dinamap®. Thirty patients were studied after carotid endarterectomy allowing comparison over a range of blood pressures much higher than in Nystrom's study. Of 558 paired measurements, 340 concerned intraarterial systolic pressures greater than 160 mmHg (table 1). Although these data generally agree with Nystrom's in the normal range, a large discrepancy appears as systolic pressure increases. Were values in this range included in Nystrom's data, a lower correlation coefficient and regression coefficient between direct and indirect pressures would have been obtained. The practicing anesthesiologist should be aware that systolic pressure in the hypertensive range is significantly underestimated by the Dinamap®.

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**REFERENCE**


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**Translaryngeal Guided Intubation Using a Sheath Stylet**

To the Editor—Every anesthetist is aware of the consequences of acute airway obstruction and should be trained to cope with this problem when it arises. However, maintaining a patent airway is not always attainable, particularly when repeated attempts at endoscopic or blind intubation have failed and have left a bloody field, preventing optimal visualization. To deal with this challenging problem, we have developed a new technique of translaryngeal guided intubation (TLI) by using a guide wire and its plastic sheath protector.

Our modified method of TLI employs the use of a spring wire originally designed to be used as a guide wire for arterial cannulation (Argon® 395203, diameter 0.021 mm, length 80 cm). After puncturing the cricothyroid membrane with a 20 GA Angiocath®, the wire is passed cephalad into the oropharynx and out the mouth or into the nasopharynx and out one of the nostrils. Instead of placing an endotracheal tube directly over the guide wire, we use the plastic sheath protector (that came with the spring wire), which was previously cut to 70 cm and straightened for easy manipulation. After the plastic sheath passes into the larynx, the spring wire is withdrawn from above to permit the sheath to be inserted deeper and to prevent possible contamination of the superficial soft neck tissues. A well-lubricated endotracheal tube then is inserted to the desired distance using the plastic sheath as a stylet.

To date we have used this technique in six patients without failure. We believe because the sheath is small and firm, similar to an ordinary stylet that we use every day, and because the sheath is inserted over the wire it is much easier to manipulate. The only drawback of the sheath stylet is its acute curvature, which may need to be straightened before use and that sometimes require pre-warming. This problem could be easily resolved if a ready-made sheath stylet was made available. Because the spring wire used is designed for intravascular use, its floppy tip will not damage laryngeal or pharyngeal structures.

The technique is generally referred to as “retrograde intubation,” since the endotracheal tube is not inserted from below, although the guide wire is. We therefore have suggested that it would be more appropriate to call this technique “translaryngeal guided intubation.”

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**Intraoperative Coronary Spasm in a Young Woman**

To the Editor—Recently, I anesthetized a 20-yr-old woman for debridement of eschars. During the procedure, the debrided areas were covered with epinephrine-soaked sponges. A sinus tachycardia of approximately 140 beats/min ensued. I treated the tachycardia with two 0.5-mg doses of propranolol. A few minutes later, I noted an