

the consent process) with regard to the SIDE EFFECTS OF THE LOCAL. As means of different measures, there is no relationship between them.

For the latter question, the entire sample mean was 6.8 and the standard deviation was 4.18 with an $n = 60$. The side-effect group of $n = 18$ had a mean of 3.1 ± 4.14 . The no side-effect group of $n = 48$ had a mean of 7.1 ± 4.16 .

I hope this gives a clearer picture of the results. In retrospect, we recognize that we should have reiterated and fully explained the overall mean level of satisfaction of 8.1 in the results section as this truly was the crucial result of the study.

Margaret Ballantyne
Brian Milne MD MSC FRCPC
Carol Pattee MD FRCPC
Kingston, Ontario

Tuohy needles and CSE

To the Editor:

All 8.9 cm (3.5 inches) Tuohy needles are not equal in length. Combined spinal-epidural anaesthesia is now part of our everyday practice. Cerebrospinal fluid (CSF) is usually easily obtained, provided a special 11.90 cm (4 11/16 inches, Becton-Dickenson, Franklin Lakes, NJ, USA) spinal needle is inserted through the 8.9 cm Tuohy needle. We recently encountered a situation forcing us to replace our usual epidural tray (Baxter, Deerfield, IL, USA) with material manufactured by Preferred Medical Products (Thorold, Ontario, Canada). We then experienced difficulties obtaining free flow of CSF with this new material. Although the length of the shaft of the needles is the same for both

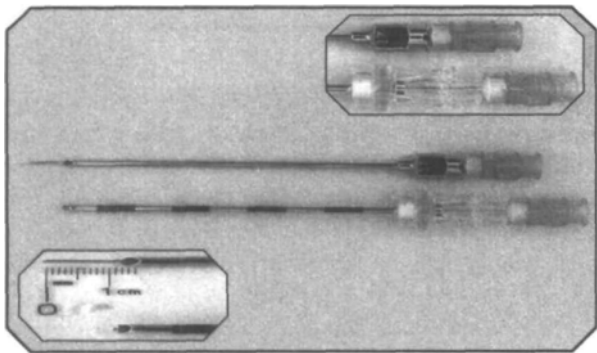


FIGURE: Top - Baxter Tuohy needle; bottom - PMP needle. A Becton-Dickenson 11.90 cm Whitacre #27 needle is inserted in both.

manufacturers, the length of the hub is longer in the second needle, providing only one mm protrusion of the spinal needle at the end of the Tuohy needle, while with the first epidural kit, needle protrusion is approximately 1.2 cm (Figure). The problem disappeared when the first epidural kit became available again.

Michel Girard MD MHPE FRCPC
Pierre Drolet MD FRCPC
Montréal, Québec

Fibreoptic cart for intubation and teaching

To the Editor:

The efficiency of fibreoptic intubation and teaching depend heavily on all necessary equipment and intubation aids being immediately available.¹ For this reason we have compiled a special fibreoptic intubation cart to make sure all needed equipment is readily at hand (Figure).

The fibreoptic intubation cart can also be used for the training and teaching of all staff and trainees in fibreoptic intubation techniques. Use of the cart for both routine clinical practice and for teaching offers obvious economic advantages. Especially the video-recorder enables us to use this cart for instruction purposes. All airway management equipment used in our hospital is available on the cart and is listed in the Table.

The cart is used for both predicted and unexpected difficult intubations. The cart has a fixed location in the operating theatre complex, where it is returned after use. The fibreoptic bronchoscope is cleaned and disinfected after use during which time we have a second bronchoscope available.

Chris Mallios MD
Marcel de Quelerij MD
Patricia Gerritsen MD
Georgio Medici MD
Frans V. Poorten MD
Erasmus University Rotterdam-Dijkzigt
Rotterdam, the Netherlands

REFERENCES

- 1 Benumof JL. Airway Management Principles and Practice. Mosby Year Book, 1996: 289, Fig 16-4.
- 2 Mallios C. A modification of the Laerdal anaesthesia mask for nasotracheal intubation with the fibreoptic laryngoscope. *Anaesthesia* 1980; 35: 599-600.