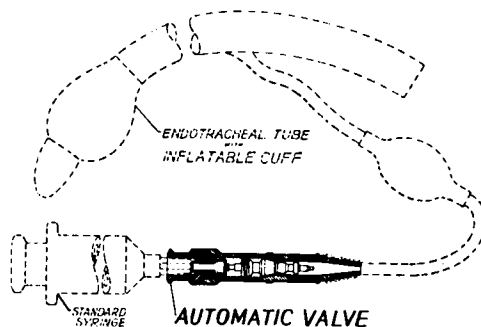


Automatic Valve

Dr. Abe O. Shapiro and the anesthesiology staff of Temple Hospital, Los Angeles, have used an automatic valve advantageously to inflate the cuff on endotracheal tubes. This valve eliminates the use of the "bulldog" clamp, hemostat, strong ties or other similar instruments which tend to crush or damage the soft rubber or plastic tubing.

This valve is light in weight, easily adapted to all caliber tubing, and is simple to use. To inflate the cuff, the plain or Luer-type tip of any standard syringe loaded with air is inserted, and then withdrawn as soon as the cuff is properly inflated. A similar procedure with the tip of an empty syringe will deflate the cuff and even maintain a vacuum.



The names and addresses of manufacturers of the equipment described in this section can be obtained from ANESTHESIOLOGY, 3 Penn Center Plaza, Philadelphia 2, Pennsylvania.

CORRESPONDENCE

Metabolic Acidosis

To the Editor.—I have reread the article of Papadopoulos and Keats [ANESTHESIOLOGY 20: 156, 1959] and checked the plot of the authors' data and find my graph to be correct, unless the tabulated data are in error.

I must apologize to the authors that very few of us in Canada play cricket. Our national sport is hockey—and this game is considerably rougher than cricket. I am sorry also that I didn't realize that they were studying the effect of intravenous glucose on the lactic acid level in the blood. (This effect was reported by Dr. Campbell [Toronto] about 30 years ago.) The title of their study stated explicitly: The Metabolic Acidosis of Hyperventilation Produced by Controlled Respiration. If any mild

metabolic acidosis was due to the rise in lactic acid (caused by intravenous glucose) the paper could have been clearer if this fact was mentioned in their discussion and summary.

In framing my remarks I took into account the details of their study, and in answering further to their reply I cannot do better than to quote Doctor Richard Asher [Talking Sense, Lancet 2: 417, 1959] who recently said, "If the technique of reducing ideas to a simple form, and placing them in logical order, were carried out extensively, only a few of our clinical ideas would come through unscathed."

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Tuohy Needle

To the Editor: I wish to refer to the article by Drs. Ralph Fritz and Robert Loehning, "Modified Tuohy Needle," which appeared on p. 712 of the September–October 1959 issue of ANESTHESIOLOGY.

I made the first needle for the late Dr. Tuohy, and I am proud of it. About fifteen

years ago I received a complaint from Dr. John Lundy regarding the sharp inside edge of the bevel, and new strict instructions were issued about blunting the sharp edge. Since then I can recall only one more complaint.

At the present time, the entire stock of Tuohy needles, 16 and 17 gauge, has been

called in for inspection and again very specific instructions regarding the blunting of the sharp edge were issued. To eliminate the danger of shearing off the end of the plastic tubing or ureteral catheter, Dr. Tuohy's instructions of withdrawal of the Tuohy needle *must* be followed. Here are his instructions.

"After the plastic tubing or Tuohy ureteral catheter has been properly placed, hold the same with the left hand about $\frac{1}{2}$ inch from the needle hub and pull the needle back that far. Move the left hand back again another $\frac{1}{2}$ inch and pull the needle that far out again. Repeat until the needle is free and can be completely

withdrawn over the remaining plastic tubing or ureteral catheter.

"Never pull the plastic tubing or ureteral catheter back through the needle, even for a short distance. This will prevent the possibility of shearing off the end of the tubing or catheter with the inner heel of the needle point."

I believe this will ease the minds of many anesthetists who are using the Tuohy needle for continuous spinal and peridural anesthesia.

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Rutherford, New Jersey

Historical Note

Dr. John B. Stetson of Boston submits another historical excerpt.

"One of the very earliest operations, prior to the first capital operation, was by Dr. John H. Dix, an oculist of that day. It consisted in a protracted but limited dissection of tissues near the eye. The inhalation was continued for thirty minutes, and was the first instance of a prolonged anaesthesia; but it was carried on with so little appreciation of the possibility of over-etherization that death would probably have resulted, if Dr. H. J. Bigelow, who was present, had not stopped its further progress

while the operation was still far from completed. The hands were cold, the respiration was very slow, and the pulse barely perceptible. The patient was etherized almost beyond recovery. It was then, for the first time, observed and pointed out by Dr. Bigelow that the pulse stood as a beacon between safety and danger,—between a harmless and a fatal narcotism. It was, in fact, the discovery of the safe use of ether."—From page 41 of *A Narrative of Events Connected with the Introduction of Sulphuric Ether into Surgical Use*, by Richard Manning Hodges, M.D., Boston, 1891.

The Society of Military Anesthesiologists

For a number of years, it has been a custom for military anesthesiologists to meet at a breakfast during the Annual Meeting of the American Society of Anesthesiologists. It became apparent, however, that there were many mutual problems pertaining to the practice of anesthesiology in the Armed Forces that deserved discussion and action on a more formal basis. As a consequence, the Society of Military Anesthesiologists was formed during the recent meeting of the American Society of Anesthesiologists in Miami Beach. Cdr Thomas C. Deas, MC, USN, Philadelphia, Pennsylvania, was elected President; Col Robert Lau, USAF, MC,

Lackland Air Force Base, Texas, Vice President; Major R. R. Hansen, MC, USA, Washington, D. C., Treasurer; and, LCdr L. D. Egbert, MC, USN, Philadelphia, Pennsylvania, Secretary. Anesthesiologists eligible for membership in the Society include regular active service anesthesiologists, reserve officers who are anesthesiologists, and civilian consultants to the Armed Forces in anesthesiology. Inquiries should be sent to LCdr L. D. Egbert, Department of Anesthesiology, U. S. Naval Hospital, Philadelphia 45, Pennsylvania. The JOURNAL wishes this new Society well in the accomplishment of its objectives.