

ference among these values. The disparity between our findings and those of Bourke and Rosenberg probably arises from differences in protocol.

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A New Method for Nasogastric Tube Insertion

To the Editor:—It is often difficult to pass a nasogastric tube in an unconscious patient after a cuffed endotracheal tube is in place. We describe a reliable, relatively simple and safe method of nasogastric tube insertion. A conventional esophageal stethoscope is modified to accept 2–3 cm of a nasogastric tube tip by cementing a thin layer of rubber from the finger of a glove over the cuff, so the proximal cuff end has a pouch. A nasogastric tube is then passed through the nose until the distal tip can be taken out through the mouth. The nasogastric tube is placed into the cuff pouch (fig. 1), and the esophageal stethoscope, along with the nasogastric tube, is then passed orally into the esophagus until maximal-intensity heart sounds are heard. This locates the tube tip distal to the endotracheal tube cuff. The nasogastric tube is then held in place and separated from the esophageal stethoscope by advancing the stethoscope 3 cm and rotating 180 degrees. The nasogastric tube is then advanced easily into the stomach. The esophageal stethoscope can be left in place or removed.

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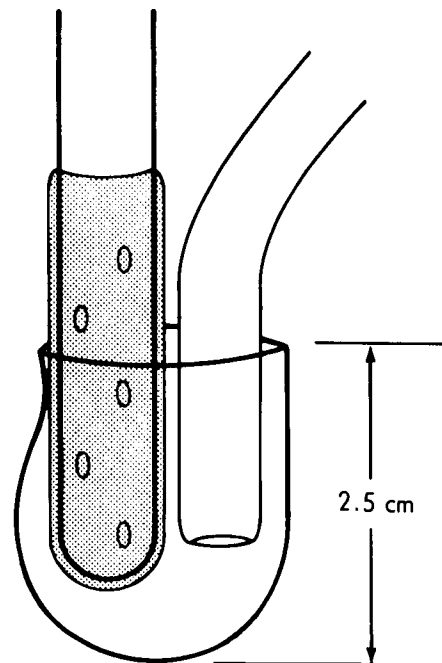


FIG. 1. The nasogastric tube tip placed in the pouch over the esophageal stethoscope cuff.

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Body Weight vs. Surface Area for Calculating Dose of Spinal Anesthetic

To the Editor:—I cannot agree with the conclusion of Dohi *et al.*¹ that the dosage of tetracaine for children is best calculated on the basis of body weight. Their

data clearly show that the time to recovery of motor function is directly related to the total doses of tetracaine. The 0.3-mg/kg dose administered to their