To enhance the timeliness of publication of Letters to the Editor, the Editorial Board approves the changes whereby prepublication proofs of Letters accepted for publication will no longer be available. Additional guidelines regarding Letters to the Editor can be found in the Guide for Authors.

Anesthesiology
64:829, 1986

More on Eponyms Used in Anesthesiology

To the Editor:—May I make a minor correction to the fascinating list of "Eponyms Used in Anesthesiology" compiled by Dr. Richard B. Clark?[1]

In the entry, "Mapleson Breathing System," Dr. Clark says that I "modified the Magill Breathing System and described it in 1954." In fact, what I did in 1954 was to publish[2] a theoretical analysis of the conditions necessary for the elimination of rebreathing in five "semi-closed" (as they were then called) anesthetic breathing systems. For convenience I referred to them as A, B, C, D, and E, and the Magill Attachment (to give it its original name) happened to be System A because it was (and still is) the most commonly used system in Britain. Subsequently, these systems have come to be referred to as the "Mapleson A," "Mapleson B," and so on, presumably as a convenient, unambiguous way of specifying them—but I did not invent, or even modify, any of them.

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Anesthesiology
64:829–830, 1986

End-tidal P_{CO_2}: Should It Be a Standard of Care in Obstetric Anesthesia?

To the Editor:—During general anesthesia for emergency cesarean section (*e.g.*, fetal distress), where the fetus is already in jeopardy, the parturient has decreased oxygen reserves and increased oxygen consumption. Consequently, the onset of hypoxia is more rapid during apnea with parturients. Unfortunately, it is sometimes difficult to ascertain correct placement of the endotracheal tube simply by auscultating the chest. Many parturients tend to be obese and have large breasts, which makes breath sounds distant and difficult to auscultate. Also, because general anesthesia is induced after the patient is fully prepped and draped, it is impractical to auscultate the epigastrium to rule out an esophageal intubation.

For the past 6 months we have routinely used end-tidal P_{CO_2} (PET_{CO_2}) monitoring in addition to auscultation to confirm correct endotracheal intubation, and we have found it extremely useful, especially in the situations where intubation proved difficult. When the tube is correctly inserted into the trachea, carbon dioxide is recorded with the very first breath, whereas esophageal intubation would show no carbon dioxide concentration with ventilation.[1] In addition, PET_{CO_2} monitoring is helpful to avoid hyperventilation and its potentially harmful consequences on the fetus.[2] We propose, therefore, that every operating room for cesarean section have a PET_{CO_2} monitor.

Of course, a similar argument has been made for the use of a PET_{CO_2} monitor in every operating room.[3] We would not disagree; however, at this time, this may not be possible for every hospital for a variety of reasons. On the other hand, we feel that the distinctive value of PET_{CO_2} monitoring in the setting of obstetric anesthesia may have been overlooked.

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Real-time Ultrasonic Guidance for Percutaneous Puncture of the Internal Jugular Vein

To the Editor:—Anatomical landmarks[1] and ultrasound Doppler flowmetry[2] have been employed for the location of the internal jugular vein (IJV). We have used transcutaneous ultrasonographic scanning to determine the precise location of the IJV and to observe the procedures of venous puncture and catheterization. An ultrasonographic scanner (Echo® Camera, Model SSD-256, Aloka, Japan) equipped with a 5 MHz ultrasound transducer was used to obtain the real-time ultrasound images. With the head rotated approximately 45 degrees contralateral to the side of the puncture, povidone iodine gel was used as the acoustic coupling medium. The probe was sterilized with ethylene oxide and applied longitudinally to the neck (fig. 1). The carotid artery is the only observable structure that bears a fixed relationship to the IJV at the levels scanned.[3] Both the IJV and carotid artery are identified as echo-free band images on the oscilloscope (fig. 2). Dur-

FIG. 1. Puncture of the right internal jugular vein. T-shaped probe is positioned in right internal jugular vein.

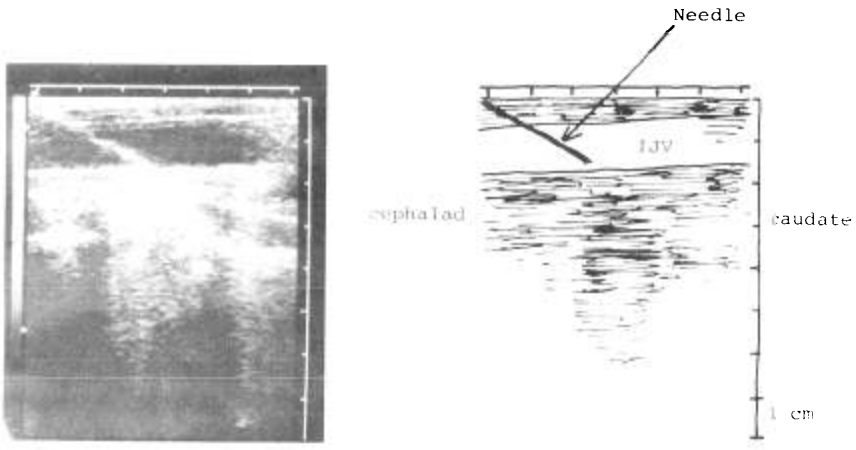

FIG. 2. The longitudinal ultrasound image of the internal jugular vein with the puncture needle in place. The internal jugular vein is observed as an echo-free band.