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REFERENCE

1. Johans TG: Multiorificed catheter placement with an intravascular electrocardiographic technique. *ANESTHESIOLOGY* 64:411-413, 1986

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The Use of an Extension Line in Epidural Anesthesia

To the Editor:—Two options that exist for epidural injection are through the needle or through the catheter. Those who prefer the needle as an injection port usually attach the syringe to the needle, then introduce incremental doses of local anesthetic with or without removal of the syringe.

As a modification of the traditional "injection by needle" technique, we place an extension line with a "T" (Abbott® 4616) between the Touhy needle and the syringe (fig. 1). The connector requires only 0.33 ml for priming and has little effect on the typical sensation during the injection, while the built-in clamp prevents back-flow.

In addition, the absence of a Luer®-type twist lock between the needle and the extension line makes the connection simple, further reducing the risk of inadvertent reposition of the needle.

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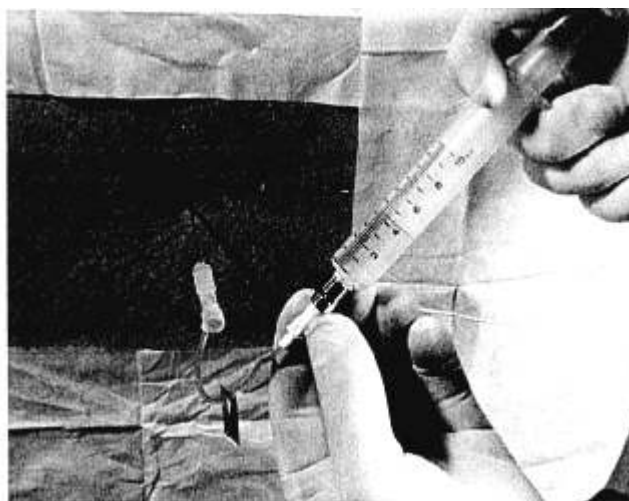


FIG 1. Illustration of extension line for epidural anesthesia.

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Tracheo-bronchial Angles in Infants and Children

To the Editor:—The article by Kubota *et al.*¹ documents the fact that there is indeed a difference in the angles subtended by the left and right mainstem bronchi at the carina in infants and children. They have, hopefully, settled a long-standing controversy.

However, they quote Brown and Fisk² (not Fish) as stating that the bevel of the endotracheal tube usually lies to the right on insertion. The fact is that the bevel of the tube faces to the left following insertion, as stated by Brown and Fisk, and the tip of the tube therefore lies to the right of the midline of the trachea. This is the reason

for the fact that the tube invariably enters the right mainstem bronchus. The normal bronchial angles are of no real significance. In fact, if one wishes deliberately to advance the tube into the left bronchus, it can be done by rotating the tube through 180° before advancing it beyond the carina.

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