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How to Make Tape Stick to Sandpaper

To the Editor:—Although the literature on how to properly tape an endotracheal tube to a patient's face is plentiful, we would like to add another report and a self-explanatory pertinent illustration on this subject.

Whenever a patient's skin is either greasy, hairy, or otherwise so uneven that normal plastic or cloth tape will not adhere properly, we use the following technique.

Once endotracheal intubation has been performed and proper tube position is confirmed, two small rectangles (3 × 7 cm) of transparent dressing (Tegaderm™, 3M, St. Paul, Minnesota) are placed on the skin overlying the cheeks or the zygomatic arch, forming a "second skin." The endotracheal tube can then be secured by the operator in the usual fashion, with the adhesive tape applied to the Tegaderm™. Contrary to regular tape, adhesion of the Tegaderm™ "second

skin" does not deteriorate with time. Even after prolonged intubation, contact remains excellent and tube displacement is very unlikely to occur. For extubation, tape is easily removed together with the Tegaderm™.

We recommend this as an efficient and clean technique to make tape stick to any patient's skin.

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A Method of Facilitating Intravenous Regional Bretylium

To the Editor:—Ford *et al.*¹ recently described intravenous (iv) regional bretylium for treatment of patients with reflex sympathetic dystrophy (RSD). We have used this technique several times with varying success. However, major problem in utilizing this technique is difficulty in establishing venous access due to the hypersensitivity and vasoconstriction caused by the RSD. We describe an approach to facilitate iv access in these patients.

A young woman presented to our Pain Clinic with a 2-month history of RSD of the right foot following an industrial accident. An iv bretylium blockade of her leg was accomplished only after great difficulty in establishing iv access. The patient had excellent pain relief for 36 h, and a repeat block was planned for the following week. Multiple attempts, including the use of nitro-paste ointment, to start an iv were unsuccessful. After

appropriate consent was obtained and adequate prehydration given a 17-gauge Tuohy needle was inserted into the epidural space *via* the L₃₋₄ interspace. Ten milliliters of .25% Marcaine was administered with the patient in the sitting position. The patient developed partial pain relief of her foot and minimal vasodilation. A 22-gauge angiocatheter was inserted and an iv bretylium block was done resulting in complete analgesia.

In summary, establishing an iv in a limb afflicted with reflex sympathetic dystrophy is often difficult because of hypersensitivity and vasoconstriction. Epidural sympatholytic block producing venodilation and some analgesia facilitates obtaining iv access for a regional block. A possible extension of this technique for an upper extremity would be sympatholysis *via* stellate ganglion blockade.