FIGURE Left, A 20-G epidural catheter with Johans electrocardiography (ECG) adapter assembly. Black arrow shows the black lead of the ECG monitor was connected to the metal hub of ECG adapter. Right, ECG tracings in a five-month old infant: catheter was advanced from the caudal space (top) until the tip reached the desired spinal T5 level (bottom) as demonstrated by the matching QRS complex of ECG tracings obtained via the surface T5 skin electrode and the epidural catheter. The tip of the catheter was later confirmed to be at the T_{4-5} interspace by chest *x-ray*.

Ban C.H. Tsui MSc MD FRCPC
Edmonton, Alberta

Reference

- 1 Tsui BC Thoracic epidural catheter placement via caudal approach under electrocardiographic guidance. *Reg Anesth Pain Med* 2001; 26: 138 (abstract).

Techniques for rigid stylet use during endotracheal intubation

To the Editor:

Use of a rigid stylet deserves an articulate Special Article such as written by Dr. Stasiuk.¹ We are disappointed, however, that our publication was not referenced.² This short letter discussed rigid stylet technique and has two similar photographs of single-handed techniques mentioned by Dr. Stasiuk. We specifically discuss two alternative methods of threading the endotracheal tube (ETT) off of the stylet. We also discuss the importance of a suitable lubricant (such as lidocaine paste) for this manoeuvre. Finally, it has a photograph illustrating how slight withdrawal of the rigid stylet moves the tip of the ETT anteriorly. We

believe that this anterior movement of the ETT tip is what makes the rigid stylet so valuable when the glottis cannot be viewed. Anterior movement of the tip does not occur when the stylet and ETT are advanced as a unit.

Michael S. Stix MD PhD
Eduardo Mancini MD
Burlington, MA

References

- 1 Stasiuk RBP. Improving styletting oral tracheal intubation: rational use of the OTSU. *Can J Anesth* 2001; 48: 911–8.
- 2 Stix MS, Mancini E. How a rigid stylet can make an endotracheal tube move. *Anesth Analg* 2000; 90: 1008.

Improving styletting oral tracheal intubation: rational use of the OTSU

To the Editor:

How fortuitous that Dr. Stasiuk's article on the "rational use of the 'oral tracheal stylet unit' (OTSU)" appears on page 911 of the October issue of the *Canadian Journal of Anesthesia* for it is clearly a cry for help! In the operating rooms (OR) at the Moncton Hospital, rather than having to ensure that my 'OTSU' is configured as in Figures 1 and 2 and then having to decide whether to hold it as in Figures 3 or 4, I simply ask my anesthesia assistant to remove the stylet. I strongly suspect that the real problem that Dr. Stasiuk is facing is a lack of a competent anesthesia assistant. If we in the rest of Canada made it a requirement that a competent anesthesia assistant be available at all times in every OR (as has been the standard enjoyed for years by our Québécois colleagues, who have a respiratory therapist to assist them in each OR), then Dr. Stasiuk would not need to figure out ways to do things on his own and publication of such articles would not be deemed necessary.

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Reference

- 1 Stasiuk RBP. Improving styletting oral tracheal intubation: rational use of the OTSU. *Can J Anesth* 2001; 48: 911–8.