LETTERS TO THE EDITOR

DEAR SIR:

It was with much interest that we read Dr. Wyant's letter to the Editor (Canad. Anaesth. Soc. J. *24*: 143 (1977)) regarding anaesthesia being a nursing process.

We agree completely with Dr. Wyant, in that this point of view, isolated or not, is cause for apprehension among physician anaesthetists.

The question of who is most suited to assist in the administration of anaesthesia, as well as what duties they should be able to perform is one that has been[1-4] and continues to be widely discussed.

Our Department of Anaesthesia employs three inhalation therapy anaesthesia technologists to aid the anaesthetists with their work in the operating room, the recovery room, and the surgical intensive care unit.

The educational background of this staff, coupled with in-hospital instruction, has enabled them to very satisfactorily perform many of the tasks in levels one to four, as described by Gravenstein.[5]

Though there are other allied health professionals who may be suited to assist anaesthetists with their workload, the anaesthetists at our hospital have found inhalation therapy anaesthesia technology personnel to be very well suited, provided that they are genuinely attracted to this type of work.

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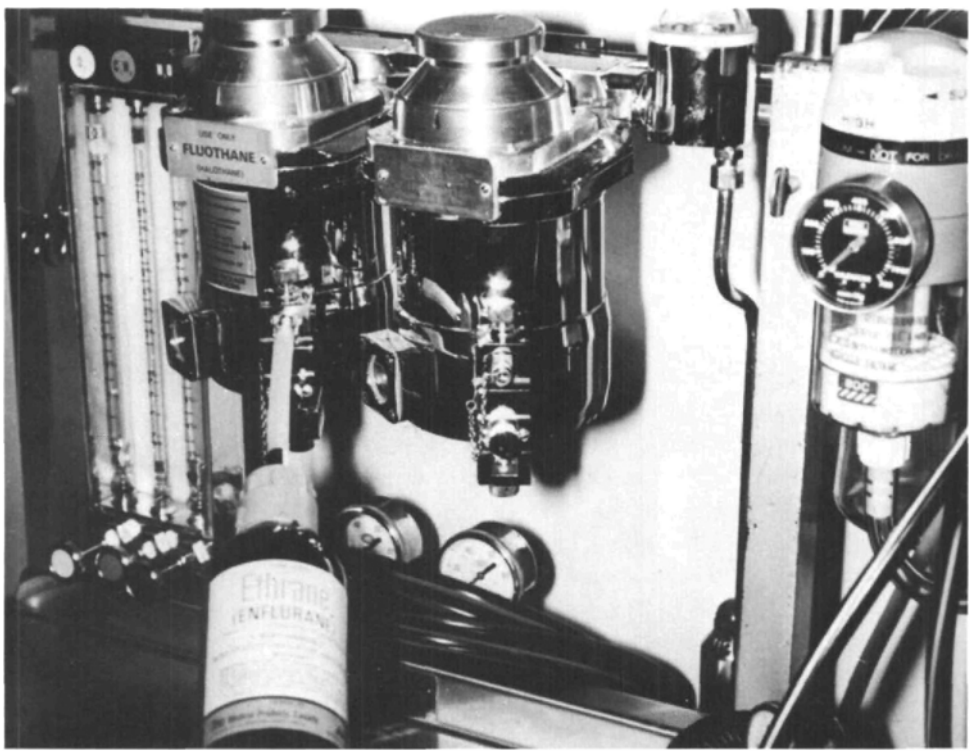
DEAR SIR:

In the past few years the probability of filling a vaporisor with the wrong anaesthetic fluid has been reduced because of the pin index system. Recently an incident took place that showed a flaw in the manufacturing of this system which could cause more errors in the future.

In the photograph, the pin for the Enflurane fits into the receptor for the Halothane, although the slots are on opposite sides for each pin. The small bead inside the receptor of the vaporisor was the reason for the misfit. This bead should stop all pins except the one that has been slotted, i.e., indexed for it. In this case the bead was either too small or had been worn down through multiple use.

The error was discovered during the filling of the vaporisor so no harm was done,



but the incident does show that the pin index system although theoretically sound could have a design improvement. A metal bar in place of the single bead in the receptor would provide a tighter and more durable fit for the indexed pins.

The pin index system is a good idea which no doubt has prevented many filling errors, but it is worthwhile to point out that this system must always be recognized as a back up to the basic safety rule that one must always read the labels before acting.

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DEAR SIR:

Maybe you would consider publishing the following case report, as I do not believe this complication of diazepam administration has been reported up until now.

A 39-year-old lady, booked for plastic surgery under general anaesthetic, was stated to be "allergic to pentothal", and although the nature of her "allergy" was uncertain, it was elected to use intravenous diazepam for induction of anaesthesia. About 1 ml (5 mg) of the drug had been injected into what was assumed to be the median antecubital vein of the left arm, when the patient screamed that she

had severe pain down the arm. It was observed at the same time that the medial border of the left forearm had become deathly pale with purple mottling, a transient phenomena lasting 15–20 seconds, and followed by a bright salmon pink flush which spread rapidly to the whole arm. The pain quickly subsided on giving a mask induction of nitrous oxide and halothane. The needle which had, of course, inadvertently entered an aberrant ulnar artery was withdrawn and no treatment of any sort was given, as the arterial supply to the arm appeared unimpaired.

On recovery from general anaesthesia the arm was found to be free of pain and a good colour. Muscular activity and skin sensation of the limb was found to be normal. Compression of the left radial artery revealed good ulnar flow to the hand.

The patient made a good recovery and no further complications developed.

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