

Correspondence

Epidural catheter disconnections

To the Editor:

Probably the most common and rarely reported complication of epidural analgesia used for postoperative or labour pain control is the separation of the epidural catheter from its connector at the Huber adapter with resultant contamination of the proximal end of the catheter (Figures A and B). Some institutions have found that catheter disconnection is the most common cause for discontinuation of epidural analgesia.¹

In spite of recommendations to the contrary² these catheters are often reconnected by nurses, physicians and even on one occasion by the patient's visitors! Sometimes the catheter is cleansed with povidone or isopropyl alcohol before reconnection, but more often the catheter is simply reattached when it is discovered lying on the bedsheets. Reconnection of the catheter puts the patient at increased risk for the introduction of microbes into the epidural space and the potential for an epidural space infection.

We recommend that, after securing the epidural catheter into the Huber connector, a protective piece of adhesive (or similar product) tape be securely attached as a "flag" around the catheter and the Luer/Huber con-

necter (Figure C). This tape is firmly applied to the connector and catheter to eliminate any chance of disconnection and maintain the integrity and sterility of the system. The "flag" can also be used to pin the connector to the front of the patient's gown or clothes to allow ready access to the catheter. One might be tempted to use the warning label enclosed in most epidural kits as a "flag" (Figure A) but we have found that it is not suitable for this purpose as it is too stiff and will not properly adhere to the adapter.

We have begun using this technique for our acute pain service and obstetrical epidurals and we have had no problems with catheter disconnections.

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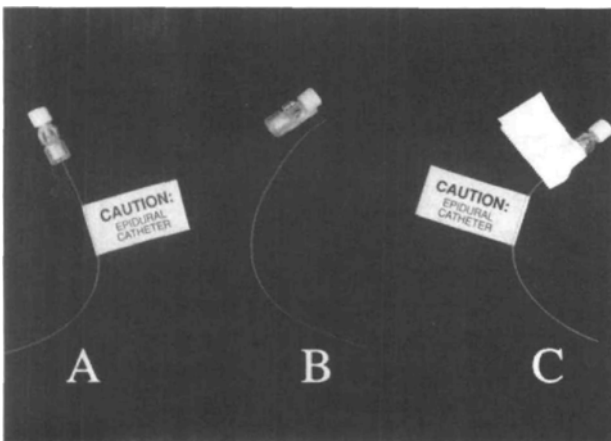


FIGURE (A) Intact Luer/Huber adapter - epidural catheter connection. (B) epidural catheter disconnected from connector at Huber adapter; (c) "flag" securely attached to catheter and adapter preventing disconnection.

General vs regional anaesthesia for minor surgery

To the Editor:

The popularity of regional anaesthesia (RA) has experienced a steady resurgence during the past decade. Although studies have shown that practicing anaesthetists would prefer to receive RA to general anaesthesia (GA) for both emergency and elective peripheral surgery,^{1,2} GA remains the technique of choice for most procedures. We conducted this survey of practicing anaesthetists to assess the use of RA in minor surgery and to examine the demographic and educational factors which may influence their choice of anaesthetic technique.

A total of 989 questionnaires was sent to all anaesthetists practicing in Ontario. In addition to demographic and educational data, respondents were asked which anaesthetic technique they would prefer if they were (a)

TABLE I Summary of anaesthetic technique

		<i>Knee scope</i>	<i>Bunions</i>	<i>Haemorrhoids</i>	<i>Carpal tunnel</i>	<i>Cataract</i>
As an anaesthetist	GA(%)	87.8	77.7	81.2	16.4	4.1
	RA(%)	12.2	22.3	18.8	83.6	95.9
As a patient	GA(%)	60.9	56.1	61.7	10.1	2.8
	RA(%)	39.1	43.9	38.3	90.0	97.2

$P < 0.01$ between GA and RA for both groups and all procedures.

TABLE II Use of regional anaesthesia

		<i>Knee scope</i>	<i>Bunions</i>	<i>Haemorrhoids</i>	<i>Carpal tunnel</i>	<i>Cataract</i>
Experience (yr)	0-10	15.5%*	31.1%*	19.4%	84.6%	97.6%*
	10+	10.1%	16.7%	18.2%	83.3%	94.6%
Practice	Community	9.3%	17.0%	14.3%	83.9%	94.6%
	University	15.5%*	29.5%*	24.5%*	83.8	97.4 %*
Training	Good	12.2%	22.7%	19.0%	82.2%	95.4%
	Poor	12.3%	22.1%	18.8%	84.6%	96.1%

* $P < 0.01$ (between groups).

a patient, and (b) the attending anaesthetist for the following five minor procedures: knee arthroscopy, bunionectomy, haemorrhoidectomy (lithotomy position), carpal tunnel release and cataract excision.

A total of 458 (46.3%) questionnaires was returned. Respondents preferred to give and receive GA more frequently for all procedures ($P < 0.01$) except for carpal tunnel release and cataract excision, where RA was the preferred technique ($P < 0.01$, Table I).¹ Fifty-nine percent of Canadian-trained and 72.3% of foreign-trained anaesthetists described their training in RA as "poor." The quality of training in RA, however, did not influence the use of RA for any of these procedures. Respondents with university-based practices used RA more frequently than GA for all procedures except for carpal tunnel release ($P < 0.01$, Table II). Respondents with less than ten years experience also chose to use RA more frequently for all procedures ($P < 0.01$, Table II).²

A lack of patient understanding of the risks and benefits of regional techniques remains a challenge to anaesthetists. In order for patients to become properly informed, however, anaesthetists must be knowledgeable and confident in their ability to administer an efficient and effective regional anaesthetic. Unfortunately, tight operating room schedules and staff anaesthetists who lack the necessary expertise in teaching RA, provide residents with suboptimal conditions in which to acquire proficiency in RA. The recent introduction of a dedicated pe-

riod of time in pain management will hopefully provide anaesthesia residents with an opportunity to develop skill and confidence in RA.

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Fibreoptic intubation

To the Editor:

Fibreoptic intubation is a valuable technique in management of the difficult airway.¹ One problem which may arise is the use of too flexible a fibrescope with too stiff an endotracheal tube, so that the tube may pull the fibrescope out of the trachea instead of following it down through the larynx.^{2,3} The use of a small diameter endo-