

GLENN COMM, M.D.
Resident in Anesthesiology

LESLIE RENDELL-BAKER, M.D.
Professor of Anesthesiology

*Loma Linda University
Loma Linda, California 92367*

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(Accepted for publication October 1, 1980.)

Anesthesiology
56:328, 1982

Exposed O₂ Flush Hazard

To the Editor:—At the end of an outpatient dental anesthesia using a Dupaco Compact 75® machine, as the drapes were being removed, the telethermometer was dislodged accidentally from the shelf above the machine. The box fell directly onto the vertically mounted O₂ flush knob jamming it into the mechanism (fig. 1). Fortunately, the anesthesiologist was just then loosening the tape fixing the tracheal tube. He immediately turned and saw the O₂ flush was jammed, and realizing the danger, disconnected the Y piece from the tracheal tube. So by prompt action the patient came to no harm, but the machine continued to discharge a high flow of O₂ until the O₂ supply was cut off. Had this accident occurred earlier when the patient's head was draped, it is doubtful whether the response could have been quick enough to prevent serious damage to the patient's lungs.

Had this O₂ flush knob been protected, say by a surrounding rim, as is now required by American National Standard Z79.8.1979, the possibility of such an accident would have been prevented.

C. EDWARD ANDERSON, M.D.
Resident Anesthesiology

LESLIE RENDELL-BAKER, M.D.
Professor of Anesthesiology

*Loma Linda University
Loma Linda, California 92350*

(Accepted for publication October 1, 1981.)

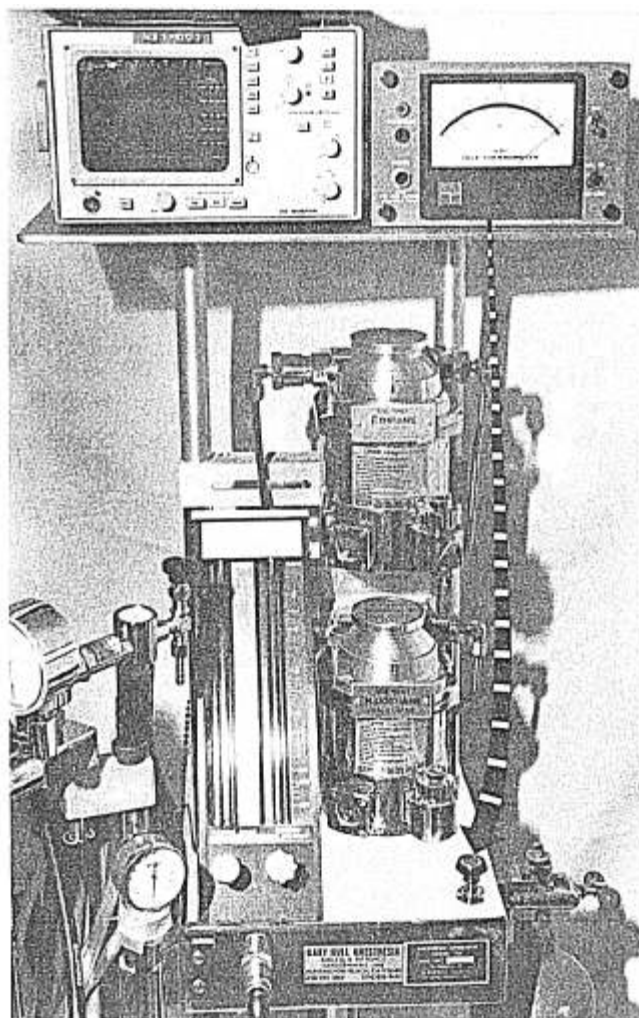


FIG. 1. A Dupaco 75® machine. The arrow indicates the telethermometer's fall onto the vertically mounted O₂ flush knob.