

Detachment of an Esophageal Stethoscope Cuff—Possible Role of an Oral Airway

To the Editor:—Dislodgement of a cuff of a disposable esophageal stethoscope which has been resterilized and reused has been described.¹ We describe the following case to illustrate the possible role an airway may play in detachment of a cuff of an esophageal stethoscope.

An 18-month-old boy underwent a revision of a ventriculoperitoneal shunt for hydrocephalus under general anesthesia. At the end of surgery, an esophageal stethoscope (reusable red rubber) was removed, with an endotracheal tube and oral airway (Berman) in place. Some resistance was felt when the terminal part of the esophageal stethoscope was being removed. After the esophageal stethoscope had been removed, the cuff of the esophageal stethoscope was missing. On direct laryngoscopy, the cuff was seen lying in the posterior pharynx. The entire cuff was retrieved (fig. 1) and there were no complications.

The design of a Berman airway provides an open air channel on each side. The advantage of this airway is that the air passages are not blocked easily by a mucous plug or foreign body.² When removing the esophageal stethoscope with a Berman airway in place, the stethoscope may get engaged in the side grooves of an airway leading to a detachment of its cuff. This would especially be true if the cuff has been weakened by multiple sterilizations.

This incidence emphasizes the need to check the esophageal stethoscope for integrity. Also, the airway probably should be removed prior to removal of an esophageal stethoscope. The airway may be reinserted if necessary.



FIG. 1. The cuff of the esophageal stethoscope removed from the posterior pharynx.

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A Simple Means of Assuring Proper Drug Dosage

To the Editor:—There are occasions in clinical practice when it is necessary to use a drug with which one does not have day-to-day familiarity as to dosage and dilution. Unfortunately, these drugs often are needed in urgent situations, when the patient's condition is unstable and there are multiple, simultaneous demands on one's attention. It is in this type of situation that mistakes of dosage or administration are most likely to occur.

To remedy this situation, I have utilized a simple and inexpensive (about \$170) hand-held computer, the Sharp PC-1211® Pocket Computer. This small (17.5 × 7 × 1.5 cm) but powerful instrument has a more than adequate memory capacity, and retains the programs

when turned off. Programming is in Basic, which is learned easily from the manuals that accompany the unit, and programs are readily brought to use by user-definable key strokes.

A sample program is listed in table 1. The subroutines at 400 and 500 are applicable to all drugs which are diluted and administered by infusion, and the main program can be tailored to a specific drug (dopamine in this instance). The divisor at 30 represents $\mu\text{g}/\text{ml}$ of solution. Since the weights of patients are given in pounds at our hospital, a conversion to kilograms is included to further simplify matters and avoid errors.

This simple program instantly reminds one of the