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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.

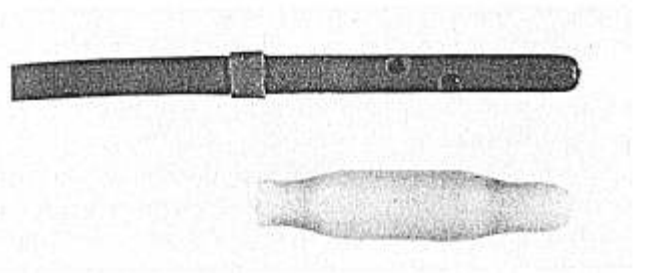

FIG. 1. The cuff of the esophageal stethoscope removed from the posterior pharynx.

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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 μg/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

TABLE 1. Sample Program

```
 10: "D" print "dopamine: 200 mg/500 ml D5W"
 20: Print "Dose=2-25 μg/kg/min": GOSUB 400
 30: X=Q/400:GOSUB 500
 40: End
400: Input "Lbs=";L,"Dose=";D
405: Q=(L/2.2)*D:Return
500: Y=X*60
505: Print using "###.##"; X; "ML OR"; Using "####"; Y;
       "MGT/MIN": Return
```

recommended dilution and dose range, and prompts for the patient's weight in pounds and the desired rate of administration. In a few microseconds, the rate is given in both milliliters and microdrops. While not as elegant as some of the programs available on larger computers, it is eminently useful, and economical as to both price and space.

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Ketamine Treatment of Status Epilepticus

To the Editor:—Recent publications regarding ketamine fail to deal with an old controversy regarding its use; namely, its convulsant/anticonvulsant properties.[1,2]

We recently were asked to consult regarding three patients in status epilepticus. Conventional therapy had failed in these patients and the use of a general anesthetic[3] presented too great a risk due to both severe hypotension and dysrhythmias. We noted an apparent temporal relationship between the cessation of both physical and electroencephalographic evidence of seizure activity and the intravenous administration of ketamine.[4]

Whether this truly represents seizure suppression by ketamine HCl is difficult to say. It is at least a consideration when faced with severely hemodynamically compromised patients in whom status epilepticus has proven refractory to conventional therapy.

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Inseparable Disposables

To the Editor:—I would like to share with you a recent experience of equipment malfunction and alert your readers to the potentially serious complications which might ensue.

During a recent hospital personnel strike, the black rubber face masks (Trimar-Ohio), normally used in this department, were replaced by single-use plastic face masks (Vital Signs—Product #5250). After induction of anesthesia, a patient was preoxygenated, paralyzed, and intubated.

When I planned to connect the patient to the anesthesia circuit, it quickly became evident that the mask