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REFERENCES

1. Simpson JI, Wolf GL: Endotracheal tube fire ignited by pharyngeal electrocautery. ANESTHESIOLOGY 65:76–77, 1986
2. Rita L, Seleny F: Endotracheal tube ignition during laryngeal surgery with resectoscope. ANESTHESIOLOGY 56:60–61, 1982
3. Hirshman CA, Smith J: Indirect ignition of the endotracheal tube during carbon dioxide laser surgery. Arch Otolaryngol 106: 639–641, 1980
4. Treyve E, Yarington CT, Thompson GE: Incendiary characteristics of endotracheal tubes with the carbon dioxide laser. Ann Otol Rhinol Laryngol 90:328–330, 1981

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Signs for Flowmeters

To the Editor:—Hospitals in developing countries are often the recipients of anesthetic machines from developed countries. Flowmeters on such machines, however, may be differently configured from machines already in use. For example, anesthetic machines from the United States may have the oxygen flowmeter to the right of the flowmeter bank, whereas on those from the United Kingdom or some European countries it is the nitrous oxide flowmeter that is located in this position. Having both types of machines in use within the same operating room suite may cause confusion among anesthesiologists or nurse anesthetists who have to use them. This confusion may lead to errors in administration of nitrous oxide instead of oxygen, with potentially lethal results.

Although monitoring devices, *e.g.*, oxygen analyzers and pulse oximeters, would give early warning of such an error, these are not readily available in developing countries because of their cost. It is obvious that a system using a single type of anesthetic machine would be best. However, given the financial constraints of hospitals in developing countries, sufficient funding often is not available to purchase machines for all the work areas. These hospitals therefore often have to rely on gifts of anesthetic machines, in good working condition, from donor countries.

In an effort to minimize the confusion that may result from using different machines and flowmeter configurations at the University Hospital of the West Indies, we have devised a system using plastic signs to make the difference between machines more visible. The signs are placed at the top of the flowmeter bank (fig. 1) and are asymmetrical and color-coded. The one for oxygen is 6 × 7.5 cm with green letters on a white background, and that for nitrous oxide is 5 × 7.5 cm with white letters on a blue background.

Measures could have been undertaken to have the oxygen flowmeter, needle valve, and inlet nipple relocated on the machines, but we believed that this might interfere with the integrity of the machine. In addition, such a procedure in a developing country would have been carried out by a non–factory-trained technician. This exercise would also have been more expensive than the cost for the signs.

Although we are not suggesting that this simple measure will completely prevent errors in the administration of oxygen or nitrous oxide, we believe that the larger signs will more readily alert anesthesiologists

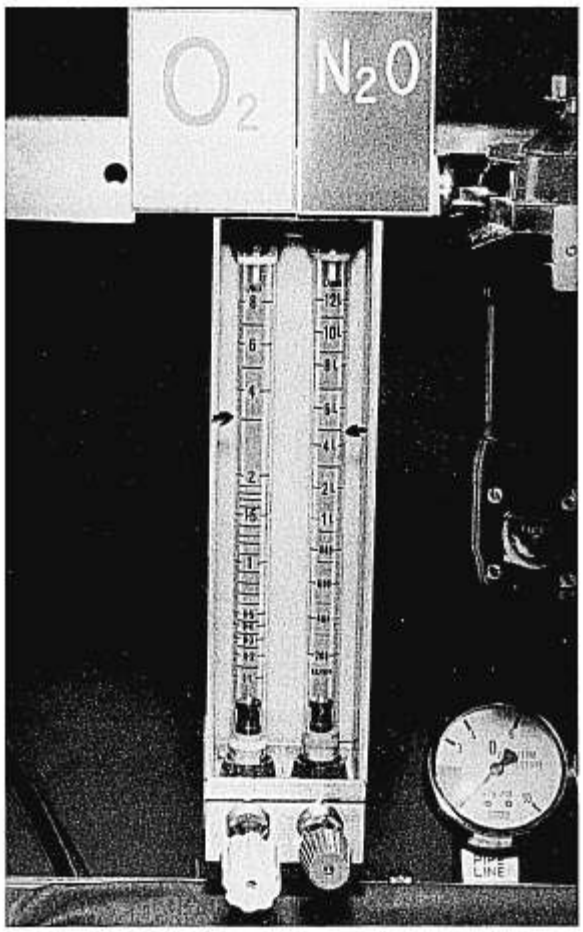

FIG. 1. Flowmeter with oxygen and nitrous oxide signs attached.

or nurse anesthetists to the location of flowmeters when differently configured anesthetic machines are in use in the same operating room suite.

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A New Dressing Technique for Temporary Percutaneous Catheters Used for Pain Management

To the Editor:—The use of catheter techniques in pain management for repeated or continuous medication delivery continues to increase. In our pain clinic, several patients, especially the outpatients, have been reluctant to consent to catheter placement due to the restrictions involved. A common complaint is that of not being allowed to shower. This restriction is common policy with temporarily placed catheters because of an inability to protect the catheter and the insertion site from moisture and contamination with the common dressing methods. Current techniques that would afford protection to the catheter and allow the patient to shower include subcutaneous tunneling or surgically implanting the catheter.[1,2]

We have recently developed an alternative dressing technique that protects the catheter and allows the patient to shower without the need for invasive procedures. The technique involves the use of a common ostomy bag device that is placed over the catheter site with the catheter inside the bag portion. We currently use the Surfit OR Set 2 Colostomy/Ostomy Device®, orifice size 4.5 cm or 5.7 cm, marketed by Squibb.

First, the catheter is placed using commonly described methods with

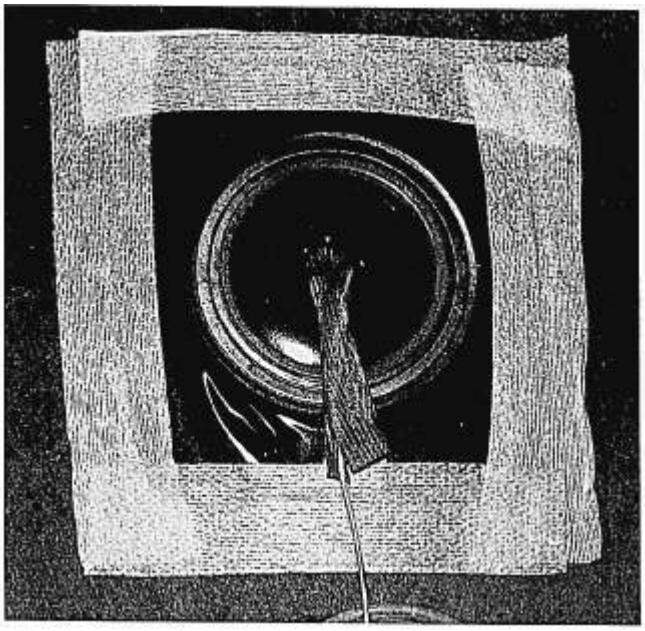

FIG. 1. Ostomy baseplate placed over catheter entry site, after catheter has been secured as described in text.

FIG. 2. Ostomy bag secured to baseplate with catheter protected inside.