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References

- 1. Komatsu T, Shingu K, Tomemori N, Urabe N, Mori K: Nitrous oxide activates the supraspinal pain inhibition system. Acta Anaesthesiol Scand 25:519–522, 1981
- 2. Ogawa T, Shingu K, Shibata M, Osawa M, Mori K: The divergent actions of volatile anaesthetics on background neural activity and

reactive capability in the central nervous system in cats. Can J Anaesth $39.862-872,\,1992$

- 3. Shimoji K, Fujioka H, Fukazawa T, Hashiba M, Maruyama Y: Anesthetics and excitatory/inhibitory responses of midbrain reticular neurons. Anesthesiology 61:151–155, 1984
- 4. Pocock G, Richards CD: Excitatory and inhibitory synaptic mechanisms in anaesthesia. Br J Anaesth 71:134–147, 1993
- 5. Roizen MF, Newfield P, Eger EI, Hosobuchi Y, Adams JE, Lamb S: Reduced anesthetic requirement after electrical stimulation of periaqueductal gray matter. Anesthesiology 62:120–123, 1985
- 6. Antognini JF, Kien ND: A method for preferential delivery of volatile anesthetics to the in situ goat brain. Anesthesiology (in press)

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A Potential Complication with the Lightwand

To the Editor:—The lighted stylet is part of the armementarium available for blind intubation of the trachea. We report a potential complication of this instrument that is an otherwise useful adjunct for intubation.

A 22-yr-old male was scheduled for elective septoplasty and rhinoplasty under general anesthesia. A single-use lighted stylet (Xomed-Treace, Jacksonville, FL) was removed from the sterile package and prepared according to instructions for insertion into an 8.0 oral RAE endotracheal tube (Mallinckrodt, Glens Falls, NY). Before inserting the stylet through the tube, a clear piece of plastic tubing 2-3 mm in length was noted to be on the stylet over the bulb, protruding slightly past the bulb and adherent to the stylet. The endotracheal tube then was placed over the stylet. However, the tube extended several centimeters past the light source, and 2-3 cm were cut from the endotracheal tube to facilitate placement with the stylet into the trachea. While the tube was being cut, the small piece of plastic tubing was noted to be lodged at the preformed bend of the oral RAE tube. A second tube was prepared and the lighted stylet, without the plastic piece, was successfully used for tracheal intubation of this patient.

The instructions accompanying the lighted stylet were consulted with no mention found of the need to remove this plastic before use.

A company representative stated that this plastic recently had been added to protect the bulb from damage during shipment and should be removed before use. In view of the difficulty with detecting this

plastic piece and the confusion that this is an integral part of the stylet, this poses a distinct hazard for unrecognized dislodgement into the tracheobronchial tree and difficulty with detection and recovery due to size and radiolucency. If protection is essential, then a red, occlusive and perhaps bulky covering that prevents use, a tag that notifies the user to remove the cover before use, or some other form of product label is in order, particularly to notify the occasional user who may be unfamiliar with the device.

We report this potential complication to warn other users and to encourage packaging modifications so that a useful device will remain available to us.

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