mend that hospital staff detach the set of adhesive dots before pulse oximetry probe use and remain vigilant in preventing opportunities for infants and young children to ingest this or other foreign material.

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In Reply:—We concur with the Drs. Reddy and Cook-Sather that clinicians caring for infants and children should make every effort to minimize opportunities for ingestion or aspiration of foreign bodies. This represents a substantial challenge to the bedside care of this patient population, particularly in an era during which so many disposables are used.

We would like to thank the authors for bringing this incident to our attention, which they did promptly after the actual clinical event. This is the first report of its kind after 10 yr of market experience with these sensor accessories. We provide the referenced adhesive dots as a convenience for our customers who wish to extend the service life of an oximetry sensor for a given patient. Because the sensor frequently remains with the child as he or she progresses through hospitalization, we have provided the adhesives on a small card that is attached to the oximetry cable itself, making them accessible for use in each new location. We might suggest that this card be intentionally secured by the involved clinicians at the opposite end of the oximetry cable to keep it out of a child's reach. Additionally, the card containing the adhesive dots can be removed entirely if there is concern about accessibility to the child.

We thank the authors for bringing this event to our attention. It will receive both recognition and serious consideration as we continually strive to make our products the best and safest available.

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Complication of Bullard Laryngoscope: Dislodgment of Blade-extender Resulting in an Upper Airway Foreign Body

To the Editor:—We will describe a previously unreported complication involving the use of the Bullard laryngoscope.

Some versions of the Bullard laryngoscope come with a separate, attachable plastic blade-extender intended to facilitate use in the larger male patient. We have recently observed two cases in which the plastic blade-extender became dislodged into the patient's hypopharynx. Both cases involved resident physicians who had limited experience with the Bullard laryngoscope. In both cases, the loss of the blade-extender was recognized immediately, and a direct laryngoscope and McGill forceps were used to retrieve the blade-extender from the patient's hypopharynx. Neither patient suffered significant morbidity.

The blade-extender snaps onto the Bullard blade with a distinct click and requires moderate force to place into proper position. Individuals unfamiliar with the blade-extender can slide it unto the blade without actually snapping it into place. The Bullard can be used successfully with the blade-extender in such an "incorrect" position. Figure 1 illustrates proper and improper placement of the blade-extender. Improper placement with subsequent displacement probably accounts for the two cases that are reported here.

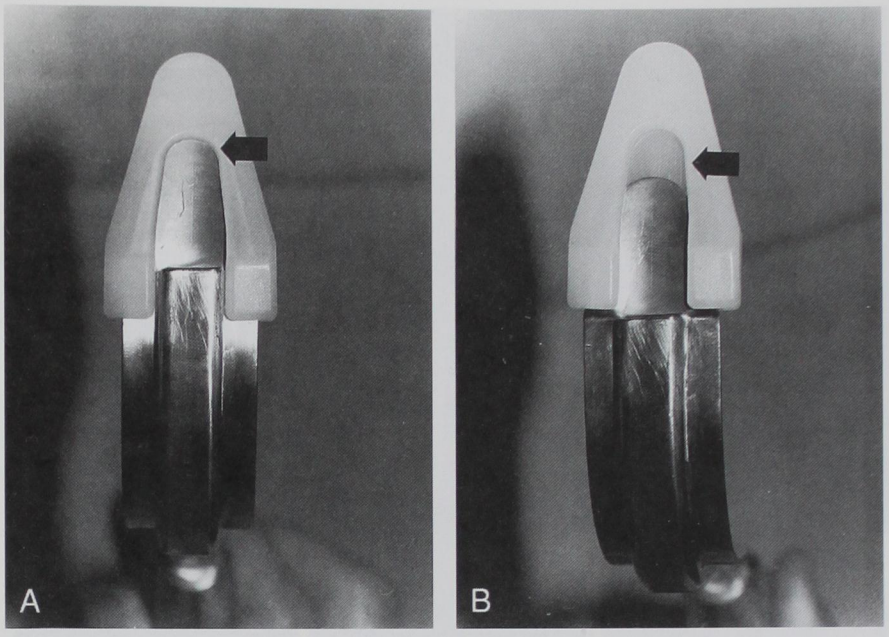

Fig. 1. (*A*) Bullard laryngoscope with blade extender in proper position. (*B*) Bullard laryngoscope with blade extender in improper position.

This report emphasizes the importance of proper training for safe use of the Bullard laryngoscope and the need for vigilance when using the blade-extender.

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High-concentration Cisatracurium in Intensive Care Unit Solution

To the Editor:—Nimbex™ (cisatracurium) is provided in 5-ml, 10-ml, and 20-ml vials. The 20-ml vial, intended for use in the intensive care unit (ICU) only, contains 10 mg/ml cisatracurium. The 20-ml vial has a similar appearance to the 10-ml operating room (OR) solution, differing in one color and having a notation on the bottom of the box as ICU use only (fig. 1). Recently, this ICU solution was placed by mistake in the OR anesthesia medication refrigerator.

It was used for anesthesia during bilateral urethral implantation in a 38-yr-old patient. This patient was a very muscular 78 kg, with medical history of hypertension and mild renal insufficiency. He was given 100 mg of cisatracurium rather than the intended 20 mg for intubation, without any hemodynamic change. Additional repeat doses of 10 mg (1 ml), 10 mg (1 ml), 10 mg (1 ml), 5 mg (0.5 ml) was given at about 65 min, 2 h, 4 h, and 5 h after the initial dose with the beginning of the recovery of first twitch out of four. A total of 135 mg cisatracurium was administered during a 5.5-h operation. At the end of the procedure, after the recovery of four out of four twitches, intravenous glycopyrrolate, 0.4 mg, and neostigmine, 2 mg, was given, and the patient was extubated without any residual neuromuscular block symptoms.

We cannot explain why this patient recovered twitch "normally" despite a fivefold overdose. This mistake was discovered only after finishing the case. Only one vial was opened during this case, and it was found to be an ICU vial, 20 ml volume and 10 mg/ml concentration.

All anesthesia personnel were notified of the existence of the ICU solution, and the ICU solution was segregated from the OR solution immediately.