To the Editor.—Although body piercing is becoming more popular and we care for patients presenting with umbilical, genital, nipple, nose, lip, and tongue rings, we were surprised to note two recent correspondences describing anesthetic management of patients with tongue rings.

There are two major concerns with jewelry in the operating room: burns and interference with appropriate medical care. Rings of any nature can be a source of “alternate-site burn.” Advances in electrosurgical technology address this concern with newer isolated electrosurgical generators designed to avoid alternate burn sites. Older models of ground-referenced generators can provide a pathway through jewelry and result in a burn. One company that produces electrocautery units states, “Patient safety is the highest concern, and one is not well served when jewelry is present.” The company states that, “it may not always be possible to remove jewelry. In these cases, the risks associated with the presence of jewelry must be assumed by the patient and the hospital.” If the companies that produce the equipment are against wearing jewelry and are willing to place the responsibility on us why should we condone wearing rings in the operating room?

Of even greater concern is allowing tongue rings in patients undergoing surgery. We cancel elective surgical procedures when the patient refuses to remove a tongue ring, recently placed or otherwise. Although we acknowledge that the hole may close, necessitating repiercing, we are unwilling to undertake airway responsibility with tongue rings present. Ring dislodgment, inability to secure an adequate airway, aspiration, pressure necrosis, injury to the tongue during airway management, and burn are potential concerns. The relaxed tongue can result in tongue-ring protrusion to a much greater extent than that noted in the previous correspondence. We congratulate the previous authors on their successful outcomes but do not agree with their approach. As Mandabach et al. demonstrate, the first anesthetic plan may not always succeed, and therefore one should always be prepared to perform general anesthesia. Although there will be emergency situations when patients will have to be cared for who have tongue rings, we believe all efforts, including cancellation, should be used when patients compromise our ability to care for them and when they place themselves at potential risk.

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In Reply.—Dr. Rosenberg and his colleagues cite their concerns about elective surgery in patients who wear jewelry in the operating room. We agree with them in this regard. It is our practice to remove jewelry from patients, if possible, before proceeding with surgery (elective and emergent). Body jewelry worn during the perioperative period poses a number of potential hazards. Pressure necrosis or nerve injury can result from ineffective padding. Lacerations can result from entanglement with drapes, gowns, and various monitor cables (electrocardiograph leads, pulse oximeter cables, blood pressure cuff tubing). In addition, electrocautery can potentially result in burns to the patient. This can occur if electrocautery is used near the site of the metal jewelry, because the current would flow preferentially, following the path of least resistance, to the metal jewelry instead of the dispersive plate of the electrosurgical unit. When current flows through an alternative return site, rather than through the dispersive plate, current density is high and serious burns may result. Burns have been known to occur when needle localization breast biopsies are performed using electrocautery, as high-density current flows

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through the needle used to localize the lesion. To avoid problems
with electrical burns, a number of precautions are taken. First, jewelry
is removed if possible; second, the dispersive plate is placed at a site
distant from the surgical field. Third, electrocautery is not used if the
jewelry is close to the site of surgery. Another option is the use of a
bipolar electrocautery unit, which uses less power, and hence the current
passes only between the tips of the unit (and not from the tip of the
monopolar unit, through the body, to the dispersive pad). It is also
important to remember that newer electrocautery units have isolated
electrosurgical generators that limit the risk of alternate site burns. The
current is isolated from the ground—it will not usually function unless
the current returning to the unit by means of the dispersive unit equals
the amount leaving the source.

This leaves us with the more important question. Is elective surgery
cancelled in a patient who wears oral jewelry? Other than issues
cancelled to electrical safety, we share similar concerns as cited by Dr.
Rosenberg and his colleagues regarding risks of oral/dental trauma,
aspiration, failure to secure the airway, and others. In the patient
reported by Dr. Rosenberg’s group, the patient has a tongue ring that
is quite long, allowing greater movement in the mouth. There is
probably even greater danger of oral and dental trauma with this type
of jewelry. If the tongue ring has been placed recently, it may not be
acceptable to the patient to remove it for the perioperative period.
If the patient’s jewelry has been in place for a while, it might be possible
to remove the piece and replace it with a nontraumatic sterile stent
(such as a loop of suture) before the induction of anesthesia. Anesthe-
sia may or may not impose additional risks for the patient who has
chosen to wear oral jewelry if the patient has been functioning with
the jewelry in place for a considerable time, going about his or her
activities of daily living. We will continue to evaluate these issues on a

case-by-case basis and would not necessarily cancel an elective case
simply because oral jewelry is present. Finally, as we mentioned in our
previous letter, we anticipate additional reports of problems and issues
with body art and anesthesia in the future.

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Oral Etomidate

To the Editor—I read with interest the article published by Streisand
et al. described as the first study in humans of oral transmucosal
etomidate. They developed a solid dosage form of etomidate for oral
transmucosal administration in humans. All adult male volunteers
received unflavored lozenges in four different strengths: 12.5, 25, 50,
and 100 mg. The authors found that drowsiness and light sleep occurred
in a dose-related manner 10-20 min after administration and lasted for
30-60 min. They also suggested that some etomidate was absorbed
through the buccal mucosa, although they could not discard the
gastrointestinal route. I am happy that their results were also in agree-
ment with our results, where we administered 1.3 mg/kg etomidate to
children as a premedication. Because we used the liquid formulation
(10 mg/ml), we set our population between 10-15 kg. We observed
that 1.3 mg/kg oral etomidate was as effective as oral 0.5 mg/kg
midazolam for handling children with the benefit of faster discharge.
The dose we used (1.3 mg/kg) seems to be in accordance with the
highest dose used by Streisand et al. if we consider that an average
healthy male adult weighs approximately 75 kg (≈1.4 mg/kg). We
agree that oral etomidate can be an alternative, although we also
observed that the children did not enjoy the taste, and we also con-
tacted the company, asking for them to prepare a more concentrated
solution with a nice taste for oral administration.

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