CORRESPONDENCE

greater than 3 beats after right ventricle opacification) or positive 99Technetium lung scan documenting greater than 5% shunt uptake over the brain or kidneys

Survey forms can be obtained from: Michael J. Krowka, M.D., 200 1st Street, SW, Rochester, Minnesota, 55905, telephone: 507-284-2921; E-mail: Krowka.Michael@Mayo.edu

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References


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A Choking Hazard during Nasal End-tidal CO₂ Monitoring

To the Editor.—Goldman¹ initially described the monitoring of end-tidal CO₂ (ETCO₂) in awake and sedated patients via nasal cannula by inserting a shortened intravenous catheter into the lumen of one of the nasal prongs and connecting this to the sampling tube from the capnograph. I used this technique to monitor expired CO₂ in a patient undergoing dilation and curettage during intravenous sedation. Intraoperatively, the patient became apneic, so the nasal cannula was replaced immediately with face mask delivering 100% oxygen. While attempting to provide assisted ventilation, I noticed a small object at the corner of the patient’s oral cavity that turned out to be the shortened intravenous catheter, which had apparently been dislodged from the nasal cannula. It was removed quickly without incident. In the process of switching from nasal cannula to face mask oxygen, the ETCO₂ sampling tube had to be disconnected first from the adapted intravenous catheter in the nasal cannula and then connected to the face mask. The nasal cannula was then removed and replaced by the face mask. In the process, the adapted intravenous catheter was unknowingly dislodged from the nasal cannula, falling into the oral cavity.

I urge anesthesiologists using this adapted method for ETCO₂ monitoring to be careful about the potential dangers that could result from dislodgement of the catheter hub.

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Fig. 1. Nasal cannula adapted with a shortened intravenous catheter for nasal ETCO₂ monitoring. The size of the adapted intravenous catheter is shown next to the nasal cannula.

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