we have received inquiries from the anesthesia community regarding the use of the PB240 pulse oximetry option with Nellcor® brand sensors. Puritan-Bennett was among the first companies to recognize Nellcor’s expertise in sensor technology and execute a license agreement to use these sensors. In order to avoid confusion we chose not to participate in Nellcor’s advertisement because Puritan-Bennett also markets an intensive care unit ventilator that uses pulse oximetry technology from Ohmeda.

We recognize the potential problems that have been raised and clearly state a warning on all oximeter cables and operator’s manuals to use only Nellcor® probes. It is important for manufacturers to share technology that furthers the goal of patient safety. However, we must also be cognizant of the potential problems that can arise and envision joint solutions.

References
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Another Site for the Pulse Oximeter Probe

To the Editor—Monitoring oxygenation is considered to be a standard of care in anesthesiology. Pulse oximetry is one of the most common measurements. Most often, the probe is placed on a finger, the nose, or an ear lobe. Alternate sites were described recently by Hickerson et al.,1 who used the tongue, and by Gunter,2 who used the corner of the mouth. We found that the shaft of the penis may be an acceptable site as well.

A 2½-yr-old male was transferred to our hospital with pneumonia secondary to respiratory syncytial virus. He required mechanical ventilation and analyses of multiple arterial blood samples for ventilatory management. Peripheral perfusion was severely diminished, and he developed arterial thrombosis of all four extremities with gangrenous digits secondary to diffuse intravascular coagulation.

We placed a disposable pediatric pulse oximeter probe (Nellcor, Heywood, CA) around the proximal shaft of the patient’s penis. Oxygen saturation readings were within 1–2% of those obtained concurrently with a probe placed on his nose. Analyses of several arterial blood samples confirmed the accuracy of the penile pulse oximetry values. There were no complications, but respiratory excursion of the abdomen caused inaccuracies in oximetry reading when the shaft of the penis rested on the pubic area.

References
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Transdermal Scopolamine and Postoperative Nausea and Vomiting

To the Editor—I read with interest the study by Bailey et al.1 which found that transdermal scopolamine is an effective antiemetic in patients undergoing outpatient laparoscopy. Another recent double-blind comparison, by Koski et al.2 found transdermal scopolamine to be of no benefit in reducing the incidence of nausea and vomiting postoperatively. The studies by Bailey et al.1 were confined to patients undergoing gynecologic surgery, whereas the patients studied by Koski et al.2 had undergone different types of surgery. These differences are resolvable if one takes into account the paper by Palazzo and Strunin,3 which describes the lower incidence of nausea and vomiting in patients undergoing gynecologic operations compared with intraabdominal operations.

The potency and dose of analgesics used may be of some significance in these studies. The doses of fentanyl used by Bailey et al.1 (0.5–2.0 μg/kg) were less than the doses of fentanyl used by Koski4 (5.0–5.0 μg/kg). In a previous study in which less potent analgesics (morphine