A Neglected Source of Nitrous Oxide in Operating Room Air

To the Editor—As a noninvasive monitoring technique, intraoperative measurement of end-tidal CO₂ is a common practice. Some of these CO₂ monitors require rather high-flow rates for sampling of gases, e.g., 150 ml/min for the Datex® Normocap CO₂ monitor or 200 ml/min for the NEC San-ei Expired Gas Monitor 1H21A®. Wasted sampling gases from these machines are another source of air pollution in the operating room. Recently, we measured nitrous oxide concentrations in the breathing zone of the anesthetist while a CO₂ monitor was in use.

In a well-ventilated room with a nonrecirculating supply of 13 air exchanges per hour, while the NEC San-ei Expired Gas Monitor 1H21A® was in use and with the anesthesia waste gas scavenger on (anesthesia gas flow of N₂O 41/min, O₂ 21/min), nitrous oxide concentrations were below 25 PPM. However, in a poorly ventilated room (room ventilator off), nitrous oxide concentrations went up to around 100 PPM in an hour. Thus, in a poorly ventilated operating room, CO₂ monitor waste gas should be scavenged as well as anesthesia waste gases. Indeed, when CO₂ monitor waste sampling gas was scavenged, we were able to keep the nitrous oxide concentration below 25 PPM.

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Lamp Placement and the Miller I Laryngoscope Blade

To the Editor.—In the June 1984 issue of ANESTHESIOLOGY, Dr. Diaz described the modifications of the straight Miller blade, suggested to facilitate laryngoscopy.1 The Miller I blades currently available differ considerably from that originally described and illustrated by Dr. Miller.2 He recognized the necessity of placing the lamp close to the distal end of the blade for adequate laryngeal illumination.

I have modified the Welch-Allyn Miller I blade by removing the distal 13 mm of the blade and refashioning the distal end with a slight curve. Figure 1 shows the standard Welch-Allyn and Penlon Miller I blades and the shortened Welch-Allyn version. The modified blade has a working length of 67 mm, compared with the original 80 mm length. On laryngoscopy, the lamp is closer to the larynx, greatly improving illumination. With the manufacturer’s models, the pharyngeal and paraepiglottic tissues often prolapse onto the lamp.

For patients up to 6 months of age, the shortened blade has no disadvantages.

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A Case of Artifactual S-T Depression

To the Editor.—Recently, during a routine cholecycctomy, new and significant S-T segment depression appeared on our Hewlett-Packard® #7830A4 ECG monitor. This occurred while we monitored lead II (fig. 1). Fortunately, the depression lasted only a few minutes and resolved spontaneously without treatment.

After resolution, we checked all the lead wire attachments; each was well secured. Then, accidentally, we found that minor movement of the patient cable holding the lead wires could produce or terminate the S-T segment changes at will.

The New Dimensions in Medicine (NDM) fully shielded ECG lead wire with snap electrode connector

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