Exposed $O_2$ Flush Hazard

To the Editor,—At the end of an outpatient dental anesthesia using a Dupaco Compact 75° machine, as the drapes were being removed, the telethermometer was dislodged accidentally from the shelf above the machine. The box fell directly onto the vertically mounted $O_2$ flush knob jamming it into the mechanism (fig. 1). Fortunately, the anesthesiologist was just then loosening the tape fixing the tracheal tube. He immediately turned and saw the $O_2$ flush was jammed, and realizing the danger, disconnected the Y piece from the tracheal tube. So by prompt action the patient came to no harm, but the machine continued to discharge a high flow of $O_2$ until the $O_2$ supply was cut off. Had this accident occurred earlier when the patient’s head was draped, it is doubtful whether the response could have been quick enough to prevent serious damage to the patient’s lungs.

Had this $O_2$ flush knob been protected, say by a surrounding rim, as is now required by American National Standard Z79.8.1979, the possibility of such an accident would have been prevented.

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Fig. 1. A Dupaco 75° machine. The arrow indicates the telethermometer’s fall onto the vertically mounted $O_2$ flush knob.