

adequate time for venous drainage. (The complication being reported was observed soon after we put our unit into service.) Slight elevation of the extremity also should aid venous flow. Finally, we suggest intra-operative inspection of the extremity with the cuff; a quick look with a flashlight under the drapes could detect venostasis. In our opinion, this very convenient automatic noninvasive blood pressure monitoring unit can be used safely with these precautions. The precautions would also apply to other automatic noninvasive BP monitors.

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Seizures Induced by Methohexital

To the Editor:—I have read the recent Clinical Report by Drs. Rockoff and Goudsouzian¹ of two children who developed seizures after the administration of methohexital. I would like to point out that seizures are a rare side effect in our experience. We have been using methohexital intramuscularly for induction in pediatric patients since November 1973. We use a 3.5 per cent solution at a dosage of 7.5–8.5 mg/kg (\approx 3.5 mg/lb). Patients with a history of seizures are not excluded. Only three patients of over 48,000 patients developed clonic type seizures. These occurred about three minutes after the injection. The convulsive pattern lasted less than ten seconds and disappeared after deepening of general anesthesia. Follow-up evaluation including EEG, failed to demonstrate an epileptic pattern or other neurological abnormalities.

In our experience, intramuscular methohexital is a most effective, dependable, and safe drug for induction in pediatric patients.

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The Risk of Endotracheal Intubation for Carbon Dioxide Laser Microsurgery of the Larynx

To the Editor:—Two recent Letters to the Editor^{1,2} point to fire hazard associated with the presence of an endotracheal tube during laser microsurgery on the upper airway. Drs. Kumar and Frost² suggest that effective protection can be achieved if the endotracheal tube is wrapped in muslin and the protecting fabric is kept moist. Unfortunately, the muslin does dry quickly during

the operation and when it does, the risk of ignition is increased.

Other authors³⁻⁵ have commented on the fire hazard associated with endotracheal tube use during microsurgery with a laser due to ignition of the tube when hit by the laser beam. This will happen regardless of whether the tube is made of plastic, rubber, or even