

the anesthesia system, and a volume monitor, to measure the volume exhaled by the patient.

In conclusion, it is important to recognize that these potential occurrences depend on the design and use of certain mass spectrometers and/or capnographs, in low-flow, closed circuit application. Both monitors provide valuable information when used and interpreted properly. However, for these monitors to be effective, they must be used in harmony with each specific anesthesia gas machine system.

Anesthesiology
66:440, 1987

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(Accepted for publication November 4, 1986.)

Corneal Abrasion During Induction

To the Editor:—The incidence of corneal abrasion during general anesthesia was reported in one study as high as 44%.¹

Recently, during an induction of general anesthesia, we identified two common, but unusual, hazards during direct laryngoscopy for endotracheal intubation.

In one instance, the anesthesiologist was wearing a waterproof watch on his left wrist, and the end of the plastic (belt style) watchband came perilously close to the patient's partially open left eye during laryngoscopy (fig. 1).

In the second, the anesthesiologist's hospital I.D. card, clipped to the vest pocket of his scrub suit, came very close to both eyes as he bent over slightly to perform direct laryngoscopy (fig. 2).

An informal survey in our department revealed that about 1/3 of anesthesiologists have similar watchbands and about 1/3 wear their I.D. cards clipped to the vest pocket.

It is common practice to attend to the protection of the patient's eyes just after induction of anesthesia and endotracheal intubation.² The two illustrations shown



FIG. 2. Plastic I.D. card perilously close to patient's left eye.



FIG. 1. End of plastic watchband noted very close to patient's left eye.

would suggest that patient's eyes should be protected before direct laryngoscopy.

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(Accepted for publication November 3, 1986.)