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(Accepted for publication November 12, 1986.)

Anesthesiology
66:447, 1987

Elastic Foamed Polymer Earplug as a Stethoscope Earpiece

To the Editor:—A precordial or esophageal stethoscope has been considered to be a fundamental monitor in pediatric anesthesia. A monaural earpiece is more comfortable than a binaural headpiece. However, unless custom-molded, the earpiece is often not used during a long operation because of discomfort.

I have found that an elastic foamed polymer earplug (Ear Whisper™, Cabot Corporation) and a disposable iv extension tube made a very comfortable earpiece, even for a long use.

The earplug is cut short, and a male adapter of an iv extension tube is inserted into the plug (fig. 1). The plug-earpiece is compressed and inserted into the auditory canal, then the earplug expands slowly in the canal and seals the space.

Since the introduction of the elastic foamed polymer earplug-earpiece, no residents have complained about discomfort of the ear.

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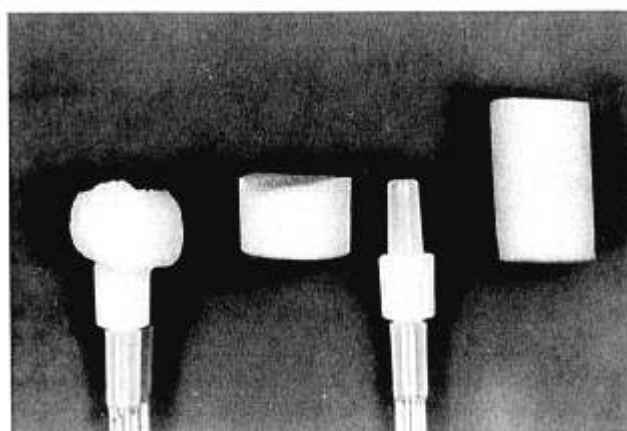


FIG. 1. Ear plug and iv extension tube make a comfortable earpiece.

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(Accepted for publication November 17, 1986.)

Anesthesiology
66:447-448, 1987

N₂O Has No Place During Oropharyngeal and Laryngotracheal Procedures

To the Editor:—We read with interest the clinical report entitled "Endotracheal Tube Fire Ignited by Pharyngeal Electrocautery," by Simpson and Wolf,¹ and we agree with their concern regarding the use of intraoral or pharyngeal electrocautery. However, we feel they missed an important opportunity to warn others and emphasize the danger when using electrocautery or laser with N₂O/O₂ combinations during upper airway procedures. Although the beneficial effect of decreasing the O₂ concentration in N₂ has not been studied in a controlled fashion with electrocautery, we feel the specific energy ignition source (electrocautery or laser) is of secondary importance to the

avoidance of N₂O and the use of a low O₂ percentage in N₂.

El-Baz *et al.*,² investigating catheter ignition by laser during the use of O₂-N₂ and O₂-N₂O mixtures, noted the critical O₂ concentration in N₂ which avoided PVC tube ignition by laser to be an FI_{O₂} of 30%. Although the use of O₂ concentrations above the critical level of 30% may be required to provide adequate oxygenation in patients with coincident pulmonary disease, the majority of those presenting for elective airway procedures should tolerate 25-30% O₂ in N₂. Whether individual clinicians use cuffed endotracheal tubes in children or not, or avoid the