



FIG. 1. Anesthesia machine oxygen hose with DISS fitting attached to air flowmeter.

the DISS standards do not apply to many adapters and regulators, including many flowmeters. In fact, it is a common practice of many respiratory therapists to interchange air and oxygen flowmeters on

ventilators they set up. In this instance, this important safety system was bypassed by the use of a flowmeter not conforming to DISS standards.

The use of a properly installed, calibrated oxygen analyzer in the anesthesia circuit alerted the anesthesiologist to this mistake before any harm was done to the patient. Perhaps all medical flowmeters and adapters should conform to the DISS standards.

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A Complication of Fiberoptic Nasal Tracheal Intubation

To the Editor:—The complication reported by Nichols and Zornow¹ is similar to an earlier report of three cases² wherein the fiberoptic was mistakenly introduced through the Murphy's eye, resulting in inability to withdraw the instrument after successful nasotracheal intubation.

Since that time we have observed that the longitudinal radio-opaque marker leading to the terminal opening on every endotracheal tube was clearly visible through the fiberoptic. We reiterate our recommendation never to pass the fiberoptic blindly but always under direct vision identifying both the terminal opening and the Murphy's eye. When in doubt, the radio-opaque marker mentioned above should help to differentiate between these two openings.

It is true that this problem can be avoided totally by loading the endotracheal tube on to the fiberoptic before insertion. It is not always easy to judge the size of the nasal passage when the fiberoptic is passed first. A 4–6 mm fiberoptic may pass easily while a 7.0 mm or a 7.5 mm ID tube, which has an external diameter of 9 mm and 10 mm respectively, may not pass, or if passed, may be pinched (compressed) by a bony spur or a narrow nasal passage. Advancing the endotracheal tube over the fiberoptic in this situation could be difficult, traumatic, and/or impossible. Passing the endotracheal tube prior to the fiberoptic will help to recognize these anatomic factors by the distortion produced in the normal contour of the endotracheal tube as seen with the fi-

berscope. If no distortion in the endotracheal tube contour is seen and the fiberoptic passes with ease through the nasally passed endotracheal tube, then that tube should advance into the trachea over the fiberoptic with minimal difficulty and trauma.

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