

It would be interesting to know how many of the unexplained cases of ulnar nerve injury occurred on the side of the blood pressure cuff. However, since most of us do not follow Sy's advice to record which arm the blood pressure cuff is on, it is probably impossible to retrieve this information.

GAYLORD D. ALEXANDER, M.D.  
*Associate Professor Anesthesiology  
Wayne State University School of Medicine  
Chairman, Risk Management Committee  
Michigan Society of Anesthesiologists*

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*In Reply:*—Dr. Alexander makes a good point in his letter. In a closed-claims review the only etiologic factors that can be considered are those focused on by the physician expert witnesses. Therefore, if a factor such as the site of an automatically cycling blood pressure cuff was not elicited during the medicolegal process, then the information was not available in the file. Usually in a case of ulnar nerve injury, the plaintiff's expert opined that the arm must have been malpositioned because there was an injury. The defense experts usually opined that ulnar nerve injury can occur without apparent causation. Dr. Alexander's letter emphasizes what we say in our paper<sup>1</sup>—that the causes of perioperative ulnar nerve injury are unknown and that large scale prospective studies are needed.

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## Improved Infection Control in the Operating Room

*To the Editor:*—In this age of increased awareness of infection and increased concern about cross contamination between physician and patient, it never ceases to amaze us to watch our anesthesia personnel carefully putting on their gloves before induction only to place the dirty laryngoscope on the clean surface that is used for all the syringes, tubes, airways, and other equipment to be used for both the current and subsequent cases. Furthermore, they use the same pair of gloves, which may have been in the patient's mouth, for continuing the case, which may include the insertion of a second intravenous catheter.

To avoid such practices, we have devised a "clean" way of performing an induction, which we encourage our residents to follow.

1. First, the anesthesiologist puts on two pairs of gloves.
2. Induction is carried out in the normal manner.
3. As soon as the endotracheal tube is in place, the blade of the laryngoscope is held in the gloved hand, and one outer glove is peeled off the hand and inverted over the dirty laryngoscope blade. The other outer glove is also removed. The anesthesiologist now has on a clean pair of gloves to pursue other tasks during the case.

*Sinai Hospital  
6767 West Outer Drive  
Detroit, Michigan 48235*

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FREDERICK W. CHENEY, M.D.  
*Professor, Anesthesiology  
Department of Anesthesiology, RN-10  
University of Washington  
Seattle, Washington 98195*

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This technique ensures that the used laryngoscope blade never comes in contact with other equipment, and that the gloves that were used for induction and intubation do not touch the chart, the needles, syringes, and other clean equipment.

This may sound a little far-fetched, but it is a positive step on the way to improving infection control procedures in our operating rooms.

FARIDA GADALLA, M.D.  
*Assistant Professor*  
JILL FONG, M.D.  
*Assistant Professor*  
*Department of Anesthesiology  
The New York Hospital/  
Cornell Medical Center  
525 East 68th Street  
New York, New York 10021*

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