progressive decreases of pressure support. On the 14th post-operative day, the patient was successfully weaned off the ventilator.

Abdominal lipectomy is a safe and reliable measure for the removal of excess abdominal fat in obese subjects. In addition, weight reduction itself is among the most effective measures to treat pulmonary complications in the obese. The removal of excessive abdominal and omental fat may have reduced intra-abdominal pressure against the diaphragm, resulting in an enhanced respiratory mechanics and successful weaning away from mechanical ventilation.

The surgery involving the thorax and upper abdomen, however, is associated with an increased risk of pulmonary complications. Moreover, obese patients have a higher incidence of postoperative pulmonary complications. The lung function can also be influenced by the type of body fat distribution (central or peripheral), and the fat removal may be more useful in the central type of obesity as in our case. Clinicians should be aware of the risks and benefits of abdominal lipectomy in different clinical settings.

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Near misses with prefilled syringes

Editor—We would like to report a potential critical incident with a prefilled suxamethonium (succinylcholine) syringe. A 23-yr-old female, ASA I, was to undergo an emergency appendicectomy. The plan for rapid sequence induction was fentanyl 100 μg, thiopental 500 mg and succinylcholine 100 mg. The fentanyl and thiopental were prepared and labelled by the anaesthetist and a prefilled succinylcholine syringe was to be used. The novice SHO performing the rapid sequence induction, under consultant supervision, accidentally picked up the succinylcholine prefilled syringe (Aurum Pharmaceuticals) instead of the fentanyl syringe but was stopped by the consultant. A potential critical incident was avoided. The label on the prefilled syringe was blue, the colour applied under the new system to opioids.

There is evidence that certain measures can reduce drug administration errors. These include the label on any drug ampoule or syringe being read carefully before a drug is drawn up or injected; the optimization of the legibility and contents of labels on ampoules and syringes according to agreed standards; the mandatory labelling of syringes; the formal organization of drug drawers and workspaces; and labels being checked by a second person before a drug is drawn up or given.

As part of the Department of Health’s drive to minimize drug administration errors in critical care areas, the Council of the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland, the Faculty of Accident and Emergency Medicine and the Intensive Care Society have all agreed to recommend the adoption of a single standard for syringe labelling. They suggest all lettering be black, with the exception of the labels for succinylcholine and ephedrine, which should be printed against the background colour as bold reverse plate letters with a black bar running from edge to edge of the upper half of the label, the rest of which shall display the coloured background. This however has not yet been applied to prefilled syringes.

We suggest strongly that all prefilled syringes for any agent be made to the current colour scheme. Aurum Pharmaceuticals have been made aware of this potential problem.

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Editor—We write to you following a near miss drug administration in our critical care unit recently. A 54-yr-old patient admitted to our unit with a diagnosis of pneumonia and cor pulmonale deteriorated despite noninvasive ventilation, and a decision to intubate and ventilate was made. Standard equipment and drugs were assembled from our crash trolley. This included a prefilled syringe of ephedrine for possible vasopressor support. Before the tracheal intubation was performed, all of the equipment and drugs were checked, whereupon it was discovered that the prefilled syringe was in fact amiodarone 300 mg. Further investigation has revealed the prefilled syringes, manufactured by Aurum Pharmaceuticals, are all contained in identical yellow plastic boxes with the name printed in black text on one face. A further classification system is used at the end of the box, employing a colour-coded label to further distinguish different compounds. Ephedrine is indicated by a pink label, whilst amiodarone employs a yellow label on a yellow box. To further confuse the issue, the same company supplies prefilled atropine syringes with a purple sticker, which are both used in many arrest trolleys across our trust.
Administration of a wrong drug could have had potentially harmful effects to our patient, and we feel this warrants further attention. Succinylcholine is supplied in a prefilled syringe but is housed in a blue box to clearly distinguish it from other medications. We would recommend the modification of the labelling system used with these syringes which will reduce the risk of potential drug errors.¹

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