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REPLY:

We agree with Dr. Tanus-Santos that clinical anaesthetists should be aware that CO₂ embolism can present in several different ways. Changes in end-tidal CO₂ in this setting depend on the amount of CO₂ delivered to the lungs in mixed venous blood, the amount of CO₂ delivered to the lungs as gas emboli, overall alveolar ventilation, and the regional alveolar ventilation of embolized lung units compared with non-embolized lung. All of these variables can change quite rapidly in the minutes following CO₂ gas embolization. For example, at the time of CO₂ gas embolism an increase in end-tidal CO₂ can occur when CO₂ gas emboli deliver CO₂ to the lungs without substantially altering cardiac output, minute ventilation, or the distribution of alveolar ventilation. In contrast, a short time later the haemodynamic effects of gas embolism may predominate. Now, a decrease in cardiac output can reduce the delivery of CO₂ to the lungs at a time when excretion of CO₂ in embolized gas has peaked and is diminishing. In this case end-tidal CO₂ can decrease. Since our data were collected at the peak of the haemodynamic effect our results tend to amplify this second phase. However, we completely agree with Dr. Tanus-Santos that clinical anaesthetists need to be fully aware of the different possible clinical presentations of CO₂ emboli.

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Infection control in outpatient facilities: caveat chirurgica!

To the Editor:

Anaesthetists do not normally appraise epidemiology literature. For the benefit of your readers I have summarised in the accompanying table, some findings from a recent report¹ that documents outbreaks of relevance to anaesthetists who provide services in private outpatient facilities.

Organism/ Source	# affected/ Type of infection	Procedures	Problems/Comments
HbsAg+/ patient	305/ HbsAg+	Plastics	MD did not use sterile technique; operated without gloves; did not wash hands between cases; reused syringes.
HIV/ surgeon	5/ HIV+	Oral surgery	HIV isolates from infected patients were identical to those from the surgeon.
HIV/ patient	5/ HIV+	General surgery	Reusable instruments were placed in glutaraldehyde 1% after use, scrubbed in running water and boiled for 5-10 min.
Adenovirus/ ?	380/ Epidemic keratoconjunctivitis (EKC)	ENT/ Ophthalmic	Poor compliance by MD with sterile precautions; poor hand washing; failure to sterilize equipment; contaminated solutions.
Pseudomonas/ patient	35/ various infections including Surgical podiatry	ENT/ Urology/	Unsterile water used for reconstituting and equipment osteomyelitis drugs; single use items were reused; poor sterile technique; defective disinfection process.
Serratia/ multi-dose vial	10/septic arthritis	Orthopaedics	Poor aseptic technique
Acromonium .kiliense/ ventilation system	4/ endophthalmitis	Ambulatory surgery	Organism was aerosolized via a defective ventilation system lacking proper filtration.
Mycobacterium/ various	31/ skin abscesses, otitis, bacteraemia and prostatic abscesses	ENT/ Urology	Staff various were putting new sterile needles on used disposable syringes; instruments were cleaned with tap water instead of being sterilized; tap water instead of sterile water was used for a prostate biopsy probe.

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