

pressures exerted by probe taping and ischemic injury caused by decreased heat dissipation.^{1,3,4,5}

The probable mechanism of injury in this case was either due to overheating of the probe secondary to the damaged light film cover or cutaneous vasoconstriction secondary to hypothermia that could have decreased the heat dissipation or combination of the both.

We suggest that one should be more vigilant in applying pulse oximeter probe in hypothermic patients. Probe should be inspected for any damage before application. It should be frequently changed from site to site to avoid prolonged contact and to inspect the area of probe application.

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Fire!

To the Editor:

We would like to report a fire involving the hot wire cautery. A 15 yr old female was scheduled for a levator sling procedure for congenital ptosis of the eye. An oxygen mask was placed on the patient's face with 5 L·min⁻¹ flow. The area was prepared with providone solution and allowed to dry completely and then infiltrated with lidocaine. A disposable, battery powered, electrocautery unit (Aaron Ram High Temperature Fine Tip 2200F, Aaron Medical Industries, Inc., St. Petersburg, Florida) (Figure) was used to control bleeding in the incision above the eyebrow. This ignited the eyebrow hair resulting in a brisk flame which was im-



FIGURE Disposable, battery powered, hand held, electrocautery unit.

mediately extinguished by hand. The patient sustained a 2 × 0.5 cm first degree burn above the left eyebrow and singed eyebrow hairs. Subsequently, the oxygen was turned off and allowed to dissipate prior to the use of the cautery and the procedure was completed without further event. The burn had healed within three days and the brow hairs returned within four weeks.

Reports of operating room fires involving the disposable cautery have involved dry sponges, drapes, and hair.^{1,2} An oxygen enriched environment is usually present but contact with any flammable object in room air can result in a fire.

We would like to reiterate the admonition from ECRI³ that supplemental oxygen should be avoided entirely or allowed to dissipate from the field for at least one minute prior to the use of the hot wire cautery.

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- 3 ECRI: Hazard Report. Fires from oxygen use during head and neck surgery. *Health Devices* 1995; 24: 155-7.