

CASE AND RESEARCH LETTER

[Translated article] Safety in Dermatological Procedures: Fire in the Operating Room

Seguridad en procedimientos dermatológicos: fuego en el quirófano

To the Editor,

Medical errors are an important cause of mortality, even greater than traffic accidents or breast cancer. Surgical fires are rare, but they can lead to significant morbidity and mortality in patients. Although it is estimated that between 200 and 240 surgical fires occur out of the 65 million surgical procedures performed each year in the United States, the actual incidence remains unknown.¹ Below are the main characteristics of surgical fires and how to prevent them.

Causes of surgical fires. Fires occur at the intersection of 3 components that form the “fire triangle”²: (a) fuel (skin, mucosa, hair, alcohol, gauze, dressings, petroleum jelly, etc.), (b) oxidizer (ambient air, supplemental oxygen, and nitrous oxide), and (c) ignition source (electrosurgical units, portable battery-powered thermal electrocautery machine, and lasers) (Fig. 1).

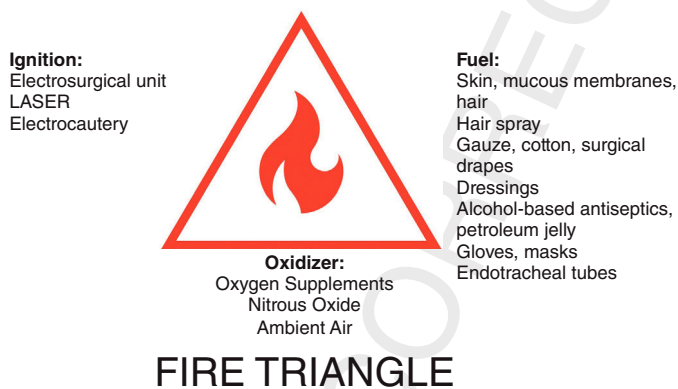


Figure 1 Fire triangle: ignition source, fuel, and oxidizer.

Ignition of gases is one of the main causes of deflagration.³ This occurs when the PaO₂ is >22%. A closed surgical field, with a “tent effect,” can increase concentration up to 53.5% at 6 L/min, with higher levels the closer it gets to the source. For this reason, it is recommended to place the source > 10 cm away. As examples to consider, a CO₂ laser at 30 W can ignite at 2 L/min with the source < 5 cm away, and electrocautery at 20 W ignites at 1 cm from the nasal cannula (Fig. 2).

Regarding antiseptics, most are alcohol-based.^{4,5} Chlorhexidine in 70% alcohol ignites at 900 °C. In a 100% oxygen environment, it ignites at 30 °C. The electrosurgical unit can ignite solutions with a 20% alcohol concentration. Additionally, the vapor produced by alcohol evaporation on contact with body heat can facilitate combustion. Therefore, it is important to dry the surgical field after antiseptics.⁶

Preventive measures for surgical fires. In the case of laser or electrocautery use, the following preventive measures should be taken^{7,8}:

- All gauze, cotton, or clothing should be removed or continuously moistened throughout the procedure.
- Hair adjacent to laser fields should be shaved or continuously moistened with saline solution or water.
- Transparent/colorless masks, nasal cannulas, and other respiratory devices should be used.
- The patient’s skin should not be cleaned with alcohol-based solutions. The patient should avoid using hair spray, colognes, or other personal care products containing alcohol before procedures.
- The inspired gas mixture should contain a minimum level of oxygen to maintain the patient’s oxygen saturation, using gases (e.g., helium, nitrogen, compressed air) and inhaled anesthetics with the lowest flammability.
- Oxygen and other gases, such as nitrous oxide should never be directed toward the field.
- If procedures close to the respiratory tract require general anesthesia with endotracheal intubation, the endotracheal tube shafts should be made of safe metal or wrapped with aluminum tape or copper foil in a spiral. In this way, tube flexing should not expose bare areas to the laser or electrocautery. Endotracheal cuffs should be filled with saline instead of air.
- Laryngeal masks with spontaneous breathing are preferred over face masks due to reduced oxygen leakage. If

DOI of original article:
<https://doi.org/10.1016/j.ad.2023.10.052>

<https://doi.org/10.1016/j.ad.2024.12.009>

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Please cite this article as: M. Linares-Barríos and I. Navarro-Navarro, [Translated article] Safety in Dermatological Procedures: Fire in the Operating Room, ACTAS Dermo-Sifiliográficas, <https://doi.org/10.1016/j.ad.2024.12.009>

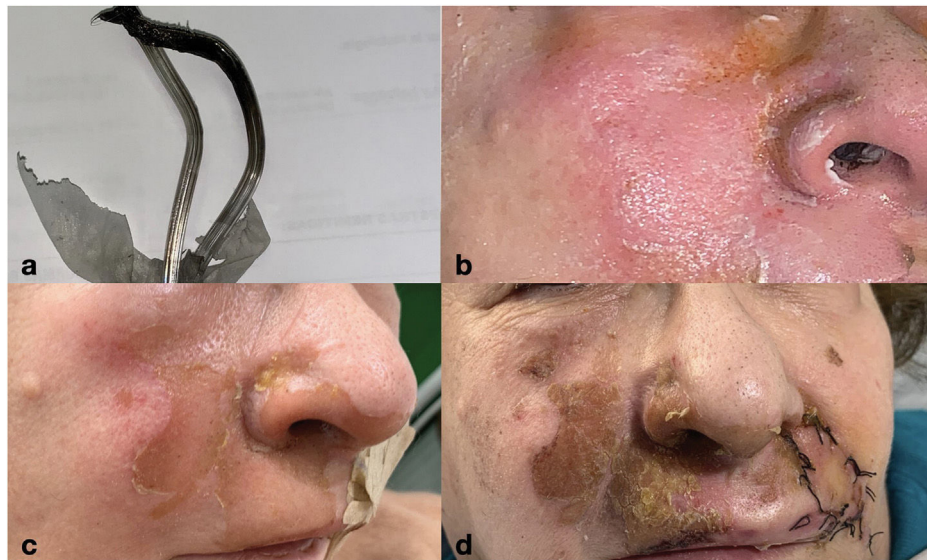


Figure 2 Case of deflagration in facial dermatologic surgery. (a) Carbonized nasal cannula. (b) Immediate condition after burn. (c) Evolution at 7 days. (d) Evolution at 14 days.

70 a face mask is used, an oxygen analyzer can be used to
71 ensure minimal leakage.
72 – Fluorocarbon cryogens are non-flammable, although ethyl
73 chloride is.

74 So far, we have been reviewing preventive measures.
75 *Actions in the event of a surgical fire.* Below is a detailed
76 response if a fire occurs in the operating room:

- 77 – An action plan for a fire should be pre-established and
78 practiced by all operating personnel.
- 79 – Water or saline solution and a fire extinguisher should be
80 available near the operating field. It is essential to always
81 know the location of the nearest extinguisher.
- 82 – In the event of a fire, ventilation should be stopped, and
83 gases should be disconnected, with removal of the endo-
84 tracheal tube, mask, laryngeal mask from the airways, or
85 nasal cannula.
- 86 – The protective goggles required for the laser make it more
87 difficult to see the start of the fire and smoke, so they
88 should be removed as soon as possible.
- 89 – Ice packs should be applied to the patient's skin after the
90 fire has been put out to minimize thermal injury.
- 91 – A flexible nasal laryngoscope or bronchoscope can be used
92 to examine the upper airways and laryngeal tissues for
93 injury.
- 94 – Thorough rinsing with water and povidone-iodine soap
95 should be used to remove carbonized debris from burned
96 areas, and antibiotic creams should be applied to skin
97 burns.
- 98 – Once the situation is under control, the correspond-
99 ing intermediate authority, usually nursing supervision,
100 should be contacted, and the safety incident should
101 be reported, with close patient monitoring and specific
102 review of the equipment used.

In conclusion, there are several factors in operating
rooms that make them a high fire-risk environment. In
addition to being oxygen-enriched, they contain flammable
materials and equipment with available ignition sources.
Although operating room fires are relatively rare events, the
consequences are potentially severe and mostly preventable
with proactive preventive measures.

Conflicts of interest

None declared.

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