able to compensate for the decrease in peripheral resistance by increasing cardiac output by approximately 0.8 l/min. These changes, however, were short-lived, and all hemodynamic parameters returned to baseline within a matter of several minutes.

We also performed radiolabeled microsphere studies and dose-response studies in rabbits, examining hypertonic glucose and hypotonic mannitol. We found that rate and dose were important factors influencing change in systemic vascular resistance and in systemic arterial pressure, i.e., the faster the rate of administration and the greater the osmotic load, the greater the hemodynamic effect. The vascular bed primarily responsive to this hypertonic load was in muscle tissue. One wonders how long the hypotension lasted in the patients studied by Goertz et al., whether this was an effect that was sustained for more than a transient period (as we observed with 25% mannitol), and whether the phenomena might have been caused by vasodilation of the vascular supply to muscle tissue, resulting in a reflex rather than a direct cardiac effect.

Charles J. Coté, M.D.
Professor of Anesthesia and Pediatrics

Northwestern University Medical School
Vice Chairman
Director of Research
Department of Pediatric Anesthesia
Children's Memorial Hospital
2300 Children's Plaza
Chicago, Illinois 60614

References
(Accepted for publication October 27, 1995)

Defective Carbon Dioxide Absorber as a Cause for a Leak in a Breathing Circuit

To the Editor—We would like to bring to attention an unusual cause of a leak in the breathing circuit of a carbon dioxide absorber cannister (Soda Sorb SN 6505-00-782-6484, WR Grace, Lexington, MA).

During a routine preuse machine check, we noted a leak within the breathing system. Visual inspection of the breathing circuit did not reveal the source of the leak, and all joints appeared to be intact.

A draft could be felt near the carbon dioxide canister. Initially, we thought that they were misaligned and removed them and changed them from top to bottom. However, the leak persisted. Thinking that the absorbers were still out of alignment, we removed them from the housing. This caused some free granules to fall to the floor. On closer inspection of the canister, it was noted to be defective. The canister is made of a clear plastic cylinder, filled with absorbent
Intraoperative Latex Anaphylaxis Observed in a Farmer

To the Editor.—Contact urticaria to natural latex and its products, such as rubber gloves, balloons, and condoms, is a well known allergy type (type I). Furthermore, latex hypersensitivity was recently recognized as one of the major IgE-mediated intraoperative anaphylaxis (type II). The risk group for latex hypersensitivity includes health care workers, hospital employees, people wearing household rubber gloves, atopic persons, rubber industry workers, and patients, especially children who have multiple surgeries and catheterizations with latex catheters.1

We encountered an intraoperative latex anaphylaxis in a patient from the eastern part of Turkey who is an practicing farmer in his own land. This 55-year-old male patient had undergone a lower lip epidermolysis operation. It was noted that the patient was undergoing a surgery for the first time in his life. Meperidine (60 mg) was used for sedation, and induction of anesthesia was achieved using 5 mg/kg fentanyl, 5 mg/kg thiopental, and 0.1 mg/kg vecuronium followed by intubation. Anesthesia was maintained by oxygen/nitrous oxide and 1% enflurane. Forty-five minutes after the start of surgery, blood pressure decreased from 110/80 to 60/50 mmHg, and pulse increased from 80 to 110 beats/min. Extensive urticaria had developed on the skin, and severe bronchospasm was heard. Oxyhemoglobin saturation decreased to 85%. All the anesthetic agents were discontinued, and the lungs were ventilated with 100% O2. Despite rapid intravenous administration of crystalloid and colloid solutions, blood pressure decreased to 30/0 mmHg. Ten- and 20-μg doses of intravenous epinephrine were given, and 250 mg methyl prednisolone granules and covered with a perforated lid, which is then heat-sealed to the top edge of the cylinder. This canister was defective because the edge of the lid had not been properly sealed with the canister before heat-sealing. The height of a currently sealed canister is 29 mm; our canister edge was 94 mm, leaving a 5-mm increase in canister height (fig. 1). This resulted in a gap between the lid and the side wall of the canister, which allowed gases to escape from the breathing circuit. The problem was easily solved by replacing the canister. However, this case reiterates the need to conduct a thorough pre-use check of the anesthesia machine.

A. M. Khatari, M.D.
Resident of Anesthesia
C. P. Kingsley, M.D.
Associate Professor, Anesthesia
Department of Anesthesia
Pennsylvania State University
P.O. Box 850
Hershey, Pennsylvania 17033

(Accepted for publication October 27, 1995.)