CORRESPONDENCE

only at the end of the procedure. Furthermore, hypercarbia at the conclusion of the case (due to incomplete reversal) would have reduced the central nervous system toxicity/convulsive threshold to bupivacaine. The signs noticed in this case, i.e., dystonic movement and prolonged emergence from anesthesia, thus might have been related to a high blood concentration of bupivacaine. It was unfortunate that the blood bupivacaine concentration was not measured.

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References


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Unanticipated Difficult Intubation in Two Family Members

To the Editor—A 47-yr-old woman and her 70-yr-old mother experienced difficult intubations within 2 months of each other while undergoing general endotracheal anesthesia.

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Preoperatively, the daughter’s airway revealed a three-finger-breath mouth opening with partial visualization of her uvula, three-finger-breath thyroid-mental distance, adequate neck mobility, and...
Technical Failure of Desflurane Vaporizer Tec-6

To the Editor.—We would like to report a case in which we encountered two problems with the Ohmeda Tec-6 vaporizer: (1) a significant fresh gas leak developed after Tec-6 was turned off, and (2) neither the Tec-6 nor other vaporizers (isoflurane and enflurane), which were mounted on the same anesthesia machine, could be turned on after the Tec-6 was turned off.

The patient was a 44-year-old man who had undergone septrhino-plasty under general anesthesia with nitrous oxide and desflurane in oxygen using a Tec-6 vaporizer mounted on a North American Draeger anesthesia machine (Narkomed 2B). The induction and intraoperative course were uneventful. At the end of the procedure, desflurane was turned off, and the patient’s trachea was extubated. On attempting to assist his ventilation via mask and despite a tight seal of the mask and a high flow of oxygen, it was noted that the reservoir bag could not be filled with oxygen. The fresh gas flush button was pushed several times while the adjustable pressure limiting valve was closed to allow filling of the reservoir bag. However, the reservoir bag only minimally filled while the oxygen flush valve was continuously activated. During these maneuvers, the selector switch was turned to the “bag” mode. While flushing, we could hear a leak around the area of the Tec-6 desflurane vaporizer. Because the patient was still unconscious and required a more secure airway, his trachea was electively reintubated and the lungs were ventilated using a manual self-inflation resuscitation (Ambu) bag. We tried to manipulate the dial of the desflurane vaporizer as well as the concentration dial of the other vaporizers that were mounted on the anesthesia machine to determine whether the “leak” situation could be corrected; we found that all of the vaporizers were in a locked “off” position and could not be turned on. Another anesthesia machine was brought into the operating room, and we subsequently ventilated the patient’s lungs in a normal and uneventful manner.

The Tec-6 vaporizer used to deliver desflurane differs in design from the variable bypass concentration-calibrated vaporizers (such as the Ohmeda Tec-4 and Tec-5 and the Draegerwerk Vapor 181).

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