Intrathecal Morphine and Reactivation of Oral Herpes Simplex

Associate Professor of Anesthesiology
Department of Anesthesiology
Parkland Memorial Hospital
5201 Harry Hines Boulevard
Dallas, Texas 75235

REFERENCES


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A Disadvantage of Similar Machine Controls

To the Editor:—This is a report of a critical incident that had the potential for causing patient injury. The incident involved a North American Drager model 2A anesthesia machine incorporating an integral oxygen analyzer. Additional monitors consisted of a Marquette model 7010 with pulse oximeter and a Perkin Elmer mass spectrometer servicing twelve operating rooms.

Figure 1 shows the vertical spacing of the controls, specifically the main on-off switch, and the on-off switch for the ventilator. On closer examination, one sees that these switches are exactly the same shape and size. They turn in the same direction and are actuated by a quarter turn. It is important to note that the on-off switch not only turns off the flow of all gases, but more importantly, turns off all audible airway pressure alarms and the oxygen analyzer.

The case in question was an uneventful cholecystectomy using a standard inhalational technique with isoflurane, 70% nitrous oxide and pancuronium. After administering reversal of neuromuscular blockade, the anesthesia trainee was intent on observing the surgical field and reached behind himself (without looking), presumably to turn off the ventilator, and made the error of turning off the main on-off switch. The mode select valve was thrown from "auto" to "bag"; the pop-off valve was closed; and when the bag was squeezed the chest was observed to rise and fall with prompt refilling of the bag. The capnograph showed a normal waveform and end-tidal carbon dioxide. It was believed that there was adequate ventilation and oxygenation. In fact, because there was no gas flow, there ensued a rapid decrease in the fractional inspired oxygen concentration (FiO2) due to consumption...
Spinal Anesthesia in Infants: Could a L5–S1 Approach Be Safer?

To the Editor.—Recently Wright et al.1 described four cases of high spinal anesthesia in former premature infants. The authors highlighted factors related to the extension of the block, i.e., baricity, position, total dose, volume of cerebrospinal fluid, volume of the anesthetic solution, and the rate of injection. However, we believe that in neonates the level at which dural puncture is performed plays a crucial role in governing the height of the spinal block. In all the infants, lumbar puncture was performed in the L3–L4 interspace.

Wright et al.1 stated that because the spinal cord and canal in infants are much shorter than in adults, small differences in the extent to which the solution ascends with injection could make a significant difference in the height of the block. We agree and suggest that a low approach, such as below the intercrystal line (which in neonates is mainly L5–S1), may reduce the possibility of high spinal blockade.

In addition, lumbar puncture at L3–L4 increases the risk of damaging the spinal cord, which is said to extend further caudal in small children.

WALTER G. MAURER, M.D.
Staff Anesthesiologist
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106

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PAOLO BUSONI, M.D., L.D.
Professor of Anesthesiology
ANDREA MESSERI, M.D.
Department of Anesthesia and Intensive Care
A. Meyer Children Hospital
Firenze, Italy

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