mmHg and the heart rate 120 bpm. Endotracheal intubation then was performed without the use of any additional medications. The patient began spontaneous respiration 30 min after intubation. Auscultation of the lungs revealed rales in the left lung field. A chest film demonstrated unilateral pulmonary edema of the left lung, which rapidly was resolved with iv furosemide. The trachea was extubated 2 h later. Follow-up ECGs essentially were unchanged from the pre-operative ECG. A neurological examination several hours later revealed no deficits. The patient had his surgery successfully performed at a later date under general anesthesia with no complications.

The gradual onset of unconsciousness and apnea over the course of 7 min without any accompanying seizures and/or cardiac collapse tends to minimize the likelihood that the observed complication was due to accidental intravascular local anesthetic injection. A more plausible explanation is that accidental brain stem anesthesis was produced. The clinical course of our case has many similarities to that described in other reported cases of brain stem anesthesis.1,2 Accidental access to the cerebrospinal fluid during retrobulbar nerve block could occur by perforation on the meningeal sheaths that surround the optic nerve. Lombardi4 reported the presence of contrast medium in intracranial subdural spaces in three out of 150 patients following retrobulbar injections of contrast for orbitography.

Brain stem anesthesis is a potentially life-threatening complication that can occur after a retrobulbar injection. Awareness and recognition of this emergency is important for all personnel involved. Individuals trained in airway maintenance and ventilatory support should be immediately available whenever retrobulbar nerve block is utilized.

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Safety of the Sitting Position

To the Editor:—Within the neuroanesthesia and neurosurgical community there seems to be considerable concern about the safety of the sitting position. Much of the negative rhetoric about the sitting position is based on anecdotal experience rather than even rudimentary epidemiologic work.

From the years 1966 through 1983, we have performed 3,827 anesthetics for cervical laminectomy or posterior fossa surgery in the sitting position. Of these there has not been a single death in the operating room due to air embolism. One patient died postoperatively from “adult respiratory distress syndrome,” which may have been related to air embolism occurring during the operative procedure. Another patient had paradoxical air embolism with severe neurologic sequelae. The only intraoperative death in our neurosurgical practice during that time period directly related to air embolism was a patient having surgery in the prone position.

Perhaps these figures can help put the risk of the sitting position into some general perspective.

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