undergoing general anesthesia for emergency cesarean section because of fetal distress. Being familiar with the specific case problems in our locale, we recommend that several actions be incorporated into the routine management of the obstetric patient. First, as with any patient about to undergo general anesthesia, assessment of the difficulty of endotracheal intubation should be part of the preoperative evaluation. When difficulty is anticipated, awake placement of the tube or regional anesthesia should be considered. Second, operation should not begin until adequate aeration of both lungs has been confirmed. When a difficult intubation is encountered without forewarning, anesthesia should be discontinued and the mother be permitted to awaken so that a different anesthetic method can be employed. Unless the section need be performed for an urgent maternal reason, such postponement may be livesaving for the mother. Third, a means of instituting transtracheal ventilation, including a sterile tracheostomy tray and a tube device such as that described by Stinson,[1] should be instantaneously available in every delivery room.

GERTIE F. MARX, M.D.
Department of Anesthesiology
Albert Einstein College of Medicine
Bronx, New York 10461

MIECZYSLAW FINSTER, M.D.
Department of Anesthesiology
College of Physicians and Surgeons
Columbia University
New York, New York 10032

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Consorts in the Delivery Room

To the Editor:—Observing the polarity of opinion expressed by Drs. Abouleish and DeVore/Asrani concerning husbands in the delivery room[1] brings to mind our own experiences where we have been called upon to minister to a variety of consorts (boyfriend, mother, or husband). It is our policy to ascertain what the consort's expectations are for this delivery. These may range from hostility engendered by nature not always being kind, to profound relief that the situation may soon come under control. If the consort wishes to be present during labor and delivery, we treat the consort much as we would a third-year medical student. By explaining to the consort everything we are doing for the mother/infant, we find that the consort either becomes an active member of the birth process or electively retreats to a position where viewing the procedure is impossible.

We do take the precaution of requesting the consort to lie on the floor if he (she) feels ill and not to try to leave the delivery room. I cannot argue with the perception that there is an element of inconvenience in these situations. However, within teaching institutions, anesthesiologists are attuned to the inconvenience of observers by regular exposure to students and other faculty at their sides.

ETHAN T. COLTON, III, M.D.
Head, Anesthesiology
Department of Anesthesiology HB 004
University of Connecticut Health Center
Farmington, Connecticut 06032

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Another Cause of Gas-scavenging-line Obstruction

To the Editor:—Since the introduction of anesthesia waste-gas scavenging, there have been case reports of harm and potential harm resulting from mechanical obstruction of the scavenging line.[1,2] A hitherto unreported cause of scavenging-line obstruction is here presented.

The scavenging system in use was a 15-foot length of plastic tubing connecting the circuit pop-off valve