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.

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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.

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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

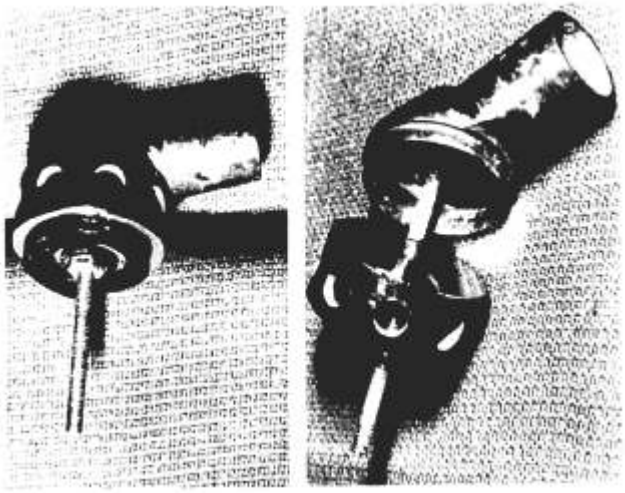

FIG. 1. Exhaust connector assembled correctly (*left*) and incorrectly (*right*).

to an exhaust connector,* which is part of a nonrecirculating ventilating system mounted on the operating room wall. This exhaust connector consists of two metal parts transfixed by a threaded bolt (fig. 1), by which it is attached to the wall-mounted extraction grille. When correctly assembled, exhaust anesthesia gases are free to spill out through the lateral holes of the system and be taken away in the air conditioning ducts. The particular unit in question was installed incorrectly, with the metal component which has the lateral holes being assembled in reverse position, resulting in total obstruction. The unit is supplied preassembled by the manufacturer; just where the misassembly occurred is not known. The defect was immediately discovered when the reservoir bag in the anesthesia circuit became increasingly tense during the first few breaths of an anesthetic. The scavenging line was disconnected from the pop-off valve, which immediately removed the risk of pulmonary barotrauma. An immediate search for the cause of high resistance in the scavenging line indicated that the problem was in the exhaust connector.

A safety interface, located distal to the popoff valve and designed to prevent positive or subatmospheric pressure in the anesthesia circuit, is essential to prevent accidents due to mechanical obstruction of scavenging lines. The exhaust connector, the source of the obstruction reported above, is widely used in North America, and attention is hereby drawn to a potentially lethal situation that may arise by incorrectly assembling the parts.

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* Exhaust connector 219-1384-800 for nonrecirculating ventilating system, Ohio Medical Products, Madison, Wisconsin.

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Hypotension with Anesthesia in Disulfiram-treated Patients

To the Editor:—Over the past year, we have observed four cases of acute, serious hypotension (greater than 50 per cent decrease from baseline blood pressure) following tracheal intubation (2) or skin incision (2) in chronically alcoholic men receiving long-term (a year or more) disulfiram (Antabuse®) therapy. The patients ranged in age from 25 to 65 years, were all undergoing nonthoracic elective procedures, and manifested no other major systemic disease. In all cases, the observed hypotension was acute, followed stable periods of normotension, and closely followed stimulating events during general anesthesia, such as laryngoscopy, tracheal intubation, or incision of the skin. The anesthetic techniques in all cases included induction with thiopental, 3 mg/kg, succinylcholine, 1.0–1.5 mg/kg, for endotracheal intubation, and maintenance with either halothane (1) or enflurane (3) and nitrous oxide, 40–50 per cent, in oxygen. In all cases, the hypotension responded to discontinuance of the inhalational anesthesia and vigorous fluid therapy alone (1) or in combination with phenylephrine (2) or ephedrine (1).

Because our observations could not be completely explained by anesthetic overdose with or without some