We have used this device in more than 100 anesthesias, and it has worked well in all cases. At present this box is not made commercially.

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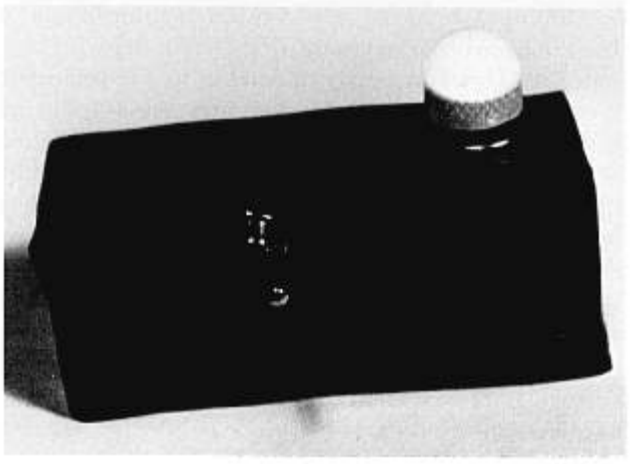

FIG. 1. Light box.

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Placental Transfer of Nitroglycerin

To the Editor:—In a recent case report,[1] prolonged depolarization neuromuscular blockade following administration of trimethaphan and succinylcholine in a pre-eclamptic parturient was explained on the basis of cholinesterase inhibition by trimethaphan. (The baby was unaffected.) It was suggested that alternative drugs such as nitroglycerin be considered for parenteral treatment in hypertensive pregnant women. There is, however, a significant difference in molecular weights and consequent predicted placental transfers between these two antihypertensive drugs.[2] Trimethaphan, with a molecular weight of 597, should have rather limited transmission across the human placenta, whereas nitroglycerin, with a molecular weight of 227, would be expected to cross readily and thereby decrease the baby's blood pressure in a manner similar to the mother's. Abnormally low blood pressures have been demonstrated in non-depressed newborns following administration of hydralazine (molecular weight 160) thereapy to mothers.[3] Neonatal hypotension is undesirable because it interferes with the normal changeover from fetal to adult circulation. We therefore believe that the safest solution to the problem is not a change in antihypertensive drug, but a decrease in succinylcholine dosage combined with continuous monitoring of neuromuscular activity by means of a nerve stimulator.

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In reply:—Drs. Diaz and Marx appropriately emphasize the importance of considering the effects on the fetus of drugs given to the mother. In addition, they correctly state that nitroglycerin may cross the placenta more readily than trimethaphan. Their recommendation to decrease the dosage of succinylcholine, however, is not an ideal solution to the problem. Our patient experienced prolonged apnea after a single dose of succinylcholine. The use of less succinylcholine might have resulted in inadequate paralysis, difficulty with intubation, and increased risk of vomiting and aspiration.

Although we agree hypotension is undesirable, it has not been observed in the first 10 min of life of neonates delivered by cesarean section to pre-eclamptic mothers receiving nitroglycerin intravenously during induction of anesthesia (F. M. James, unpublished observations). In the adult, nitroglycerin is rapidly metabolized by reduced glutathione in the tissues. The absence of hypotensive effects in the infants studied suggests that the neonate may also metabolize nitroglycerin rapidly. Our conclusion remains that investigation of the maternal and fetal effects of alternative hypotensive agents is indicated.

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More on Fathers in the Delivery Room

To the Editor:—Your readers may be puzzled by differences expressed by such eminent authorities as Dr. Abouleish,[1] and Drs. DeVore and Asrani.[2] They are both wrong to impose rigid systems in their institutions. We, too, are often asked at parent-craft classes whether the father can remain in the delivery room during clinical maneuvers. We explain that the most important concern is the safety of the mother and her baby, and differences exist among anesthesiologists; some are unaffected by the father's presence, while others feel that it could interfere with their concentration on the mother's welfare. Even an experienced clinician may not have a suitable personality to manage the situation successfully. He would indeed be foolish to proceed with the father in the room if he believed that it could impair his ability to carry out a procedure successfully. When our mothers and fathers come to understand the reasons for differences in approaches, they willingly accept these conditions. Therefore, while personally encouraging the participation of the father in all phases of the delivery, we recognize the right of others to ask him to leave, as well as that of the father to leave!

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Automatic Blood Pump

To the Editor:—Instead of using the pressure device proposed by Waldman and Rebane,[1] one can use a standard orthopedic tourniquet pump* to pressurize a Fenwal blood pump for rapid transfusion. This automatic tourniquet has a deflate–inflate knob, an increase–pressure knob, and a pressure gauge. Pump pressure can be inflated and deflated instantaneously. The pressure gauge should not be set above 300 torr or the Fenwal pump may rupture. This pump has worked well for me.

* Kidde Automatic Tourniquet, V. Mueller, Columbus, Ohio.

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