Paternal Fractured Skull as a Complication of Obstetric Anesthesia

To the Editor:—Currently, there is a trend toward allowing husbands in labor and delivery rooms. However, this participation by husbands is not without risk, as the following description indicates.

Recently, epidural anesthesia was chosen for labor and delivery for a primigravida who had been in labor for nine hours. Verbal consent was obtained from the patient and her husband. Because the patient's husband had attended prepared childbirth classes with his wife, he was given the option of staying in the labor room, which he chose to do. As the epidural needle was being removed, the patient, who was being supported in a sitting posture by her husband, had a uterine contraction. At this point the husband fainted, struck his head against the railing of another patient's bed, and fell to the floor. The husband was immediately attended to by a registered nurse present in the room and was found to be unconscious, with a pulse rate of 44/min, which increased immediately to 50/min. The wife was supported by a nurse anesthetist also present. The husband regained consciousness after 90 sec, and he remained in stable condition and conscious. Skull roentgenograms, obtained immediately revealed a non-depressed occipital fracture. The husband was admitted to the neurosurgical service for observation and discharged the following day without apparent sequelae.

Modern obstetrics encourages paternal participation in the event of birth. In the delivery room the father is encouraged to sit on a stool near the mother's head, both so he can be supportive and to minimize the likelihood of fainting. This precaution may be omitted in the labor room when the father is allowed to remain during the insertion of an epidural needle. Additionally, in our case, the father had been up all night with little or no oral intake, so that fatigue, dehydration and hypoglycemia may have exaggerated the vagal response elicited by watching a needle being inserted into the back of a loved one. We have found that fathers can be very supportive to their spouses during the institution of epidural anesthesia. However, the possibility of their fainting should be considered and appropriate precautions taken.

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Bupivacaine-induced Seizure in Obstetrics

To the Editor:—Bupivacaine is commonly used for epidural anesthesia in obstetrics. Yamashiro reported a seizure in a patient following its use. We recently had a similar case that merits comment. A 36-year-old woman, gravida II, para I, was scheduled for elective cesarean section. The patient had received general anesthesia for her first section after unsatisfactory spinal anesthesia. She consented to epidural anesthesia on this occasion after a preoperative visit. She was brought to the operating room, an epidural catheter was placed in the L3–4 interspace, and a test dose of chloroprocaine, 3 ml, 3 per cent, was given after a negative aspiration. Fifteen minutes later, when there was no sign of subarachnoid block or systemic effect, the patient was transferred to an operating table. Bupivacaine, 10 ml, 0.75 per cent, was given through the epidural catheter, again after negative aspiration. Within 30 sec the patient had a generalized seizure.

Oxygen by mask and thiopental, 100 mg, intravenously, controlled the seizure immediately. The patient regained consciousness in 6 min. An external fetal monitor was applied, and the mothers' respiration and vital signs were monitored. The fetal monitor showed slight tachycardia with some loss of baseline variability. After consultation with the obstetrician, it was elected to postpone cesarean section until the next day. The epidural catheter was removed and could be seen to contain a significant amount of blood. Cesarean section was performed without incident the following day using general anesthesia, with delivery of a vigorous infant.