

Anesthesiology
55:487, 1981

Another Sign of Inadvertent Carotid Cannulation

To the Editor:—The purpose of this letter is to add to the advice and recommendation of William T. Ross *et al.*¹ in diagnosing inadvertent carotid cannulation.

We have observed on two occasions that when the cannula is in the innominate artery, at the inception of the cardiopulmonary bypass, the entire right half of the face becomes blanched. It is very obvious and dramatic. This would happen, of course, only if the pump is primed with clear solutions. Perhaps because of early detection and correction, there were no neurologic sequelae in either of our cases.

To avoid the tragic outcome of the complication, early diagnosis is essential and close observation of the head cannot be overemphasized.

Anesthesiology
55:487, 1981

FAZLEALI Y. DALAL, M. D.
Associate Clinical Professor of Anesthesiology
The Medical College of Wisconsin

KITA D. PATEL, M. D.
Acting Chief
Department of Anesthesiology
Mount Sinai Medical Center
950 North 12th Street
Milwaukee, Wisconsin 53201

REFERENCES

1. Ross WT, Lake CL, Wellons HA: Cardiopulmonary bypass complicated by inadvertent carotid cannulation. *ANESTHESIOLOGY* 54:85-86, 1981

(Accepted for publication April 18, 1981.)

Intrathecal Morphine in Obstetrics

To the Editor:—The report by Baraka and colleagues¹ helps to strengthen my opinion that any analgesic action referable to narcotics injected either intrathecally or extradurally is centrally mediated. If the onset of analgesia coincided with those of nausea, vomiting, sleepiness and itching, it is surely sensible to assume that the former, like the latter group, reflects the action of drug within the cranium.

Of much greater importance, however, is the implied approval of the use of this technique in obstetric practice. Evidence, both published² and gathered locally, has been accumulating that respiratory depression of delayed onset is not infrequently to be observed following the intrathecal injection of 1-2 mg morphine. The delay can be as long as 10-12 hours. The complication is unlikely to be of consequence if the patient is under constant observation, as in a recovery room or an Intensive Care Unit. However, postnatal wards are characterized internationally by a low level of staffing, especially at night. The

Anesthesiology
55:487-489, 1981

prospect that an unobserved healthy postpartum patient might, in the early hours of the morning, gradually develop respiratory depression of an increasing, possibly lethal, severity, hardly bears contemplation. I contend that this technique is, for the time being at least, absolutely contraindicated in routine obstetric practice.

J. SELWYN CRAWFORD, F.F.A.R.C.S., F.R.C.O.G.
Consultant Anaesthetist
Birmingham Maternity Hospital
Queen Elizabeth Medical Centre
Edgbaston Birmingham B15 2TG
England

REFERENCES

1. Baraka A, Noueihid R, Hajj S: Intrathecal injection of morphine for obstetric analgesia. *ANESTHESIOLOGY* 54:136-140, 1981
2. Davies GK, Tolhurst-Cleaver CL, James TL: CNS depression from intrathecal morphine. *ANESTHESIOLOGY* 52:280, 1980

(Accepted for publication April 12, 1981.)

Compatibility and Stability of Pentobarbital Infusions

To the Editor:—The use of barbiturate anesthesia to decrease intracranial pressure in patients with head injury is rapidly gaining acceptance. For this purpose intermittent injections are apparently preferred over in-

fusions of pentobarbital.¹ The reason for this is unclear, but may be related to reports that aqueous solutions of pentobarbital are unstable.²⁻⁴ Since infusions would be more convenient, it was decided to assess the stability