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Anesthesiology  
64:829, 1986

### More on Eponyms Used in Anesthesiology

*To the Editor:*—May I make a minor correction to the fascinating list of “Eponyms Used in Anesthesiology” compiled by Dr. Richard B. Clark?<sup>1</sup>

In the entry, “Mapleson Breathing System,” Dr. Clark says that I “modified the Magill Breathing System and described it in 1954.” In fact, what I did in 1954 was to publish<sup>2</sup> a theoretical analysis of the conditions necessary for the elimination of rebreathing in five “semi-closed” (as they were then called) anesthetic breathing systems. For convenience I referred to them as A, B, C, D, and E, and the Magill Attachment (to give it its original name) happened to be System A because it was (and still is) the most commonly used system in Britain. Subsequently, these systems have come to be referred to as the “Mapleson A,” “Mapleson B,” and so on, presumably as a con-

venient, unambiguous way of specifying them—but I did not invent, or even modify, any of them.

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2. Mapleson WW: The elimination of rebreathing in various semi-closed anaesthetic systems. *Br J Anaesth* 26:323–332, 1954

(Accepted for publication December 17, 1985.)

Anesthesiology  
64:829–830, 1986

### End-tidal $P_{CO_2}$ : Should It Be a Standard of Care in Obstetric Anesthesia?

*To the Editor:*—During general anesthesia for emergency cesarean section (*e.g.*, fetal distress), where the fetus is already in jeopardy, the parturient has decreased oxygen reserves and increased oxygen consumption. Consequently, the onset of hypoxia is more rapid during apnea with parturients. Unfortunately, it is sometimes difficult to ascertain correct placement of the endotracheal tube simply by auscultating the chest. Many parturients tend to be obese and have large breasts, which makes breath sounds distant and difficult to auscultate. Also, because general anesthesia is induced after the patient is fully prepped and draped, it is impractical to auscultate the epigastrium to rule out an esophageal intubation.

For the past 6 months we have routinely used end-tidal  $P_{CO_2}$  ( $PET_{CO_2}$ ) monitoring in addition to auscultation to confirm correct endotracheal intubation, and we have found it extremely useful, especially in the situations where intubation proved difficult. When the tube is correctly inserted into the trachea, carbon dioxide is recorded

with the very first breath, whereas esophageal intubation would show no carbon dioxide concentration with ventilation.<sup>1</sup> In addition,  $PET_{CO_2}$  monitoring is helpful to avoid hyperventilation and its potentially harmful consequences on the fetus.<sup>2</sup> We propose, therefore, that every operating room for cesarean section have a  $PET_{CO_2}$  monitor.

Of course, a similar argument has been made for the use of a  $PET_{CO_2}$  monitor in every operating room.<sup>3</sup> We would not disagree; however, at this time, this may not be possible for every hospital for a variety of reasons. On the other hand, we feel that the distinctive value of  $PET_{CO_2}$  monitoring in the setting of obstetric anesthesia may have been overlooked.

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