Short Circuit in the Operating Room

To the Editor.—Recently a short circuit occurred in an operating room when a battery pack was plugged into a wall receptacle to be recharged. As the electrical plug was being inserted into the receptacle, the metal receptacle face plate came loose, resulting in a short circuit between the hot and neutral blades of the plug. Although there was a loud noise and a light flash, the person inserting the plug was not injured.

The proximal cause of this incident was that the screw that secures the receptacle faceplate was missing. When the hot and neutral blades of the plug made contact with their respective electrical power lines, they were short-circuited by the falling metal face plate before they could be completely covered by full insertion into the receptacle.

It used to be that electrical plugs came out of receptacles because the fit was too loose. Now, in our relatively newly constructed facility, it is just the opposite. Sometimes it is too difficult or just too much trouble to fully insert a plug. It is not uncommon to walk through an operating suite or ward and see electrical appliances operating with their electrical plugs halfway out of the receptacles. We know of similar incidents. In one, a metal needle rolled off a table and short-circuited a lamp when the shade was lowered. In another, a metal needle rolled off a table and short-circuited a monitor plug. The needle actually melted away before the circuit breaker had time to trip, leaving behind only a pair of ghostly grooves vaporized in the blades of the plug.

Another factor that may have acted to facilitate this event was the orientation of the receptacle mounting. The three slots of the receptacle form a triangle, the rounded slot being for the ground blade of the plug. In this case, the receptacle was installed with the ground-blade slot in the 6-o’clock position (pointing down). If this slot had been in the 12-o’clock position (pointing up), the ground blade on the plug (which is made the longest so that it is first to connect and last to disconnect) might have blocked the metal plate from slipping down and thus short-circuiting the other two blades. At present, there is no standard that addresses the orientation of receptacles. It would appear that the 12-o’clock position offers at least some protection, without potential adverse effects. The National Fire Protection Association should consider this question in the next revision of the National Electrical Code* (Article 517), where electrical construction in health-care facilities is discussed.

Although there were no adverse effects from this incident, we submit this report to call attention to the constant need for concern with all aspects of electrical safety. The user of electricity in the operating room should realize that plugs must be inserted fully into receptacles. Perhaps most important, personnel inserting a plug should observe the physical condition of the plug and receptacle (as well as the equipment itself). Only through education, constant vigilance, and concern of all personnel can untoward events be prevented.

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Total Spinal Anesthesia during Cesarean Section Hours after Previous Unintentional Dural Puncture

To the Editor.—Total spinal anesthesia is an unpredictable and, fortunately, unusual complication during routine spinal anesthesia. Many patient variables have been suggested as influencing the spread of spinal anesthesia. These include age, weight, height, and body mass index. Accidental dural puncture during epidural local anesthetic administration also has been associated with total spinal anesthesia.

I recently treated a parturient (36 yr old, 82 kg, 168 cm) in whom total spinal anesthesia occurred during subarachnoid administration of hyperbaric bupivacaine for cesarean section. This occurred 7 h after two unintentional dural punctures during attempted labor analgesia at two consecutive lumbar segments (L2–L3 and L3–L4). No local anesthetics (except to the skin) were administered during the attempted epidural analgesia. An urgent cesarean section was scheduled 7 h later because of persistent occiput posterior position of the fetus and arrest of the second stage of labor. I decided to perform a spinal anesthetic for this procedure because of the difficulties encountered during attempted labor epidural analgesia. With the patient

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sitting, spinal anesthesia was established with 1.5 ml 0.75% bupivaca
cine in 8.25% glucose (11.25 mg bupivacaine) through a 25-G Quincke
crane needle. Injection was performed over 15 s and be-

tween uterine contractions. Free flow of cerebrospinal fluid (CSF)
was observed. The patient was gently placed supine in a lef
tilt position using a folded blanket under the right hip. The operating table
was kept in a horizontal position.

Within 2 min, she began to develop upper extremit
ty analgesia. This rapidly progressed over the next 30 s to motor weakness of both
hands and respiratory distress. Hypotension was not noted. Because of
the obvious respiratory distress, mechanical ventilation of the lungs
was instituted with 100% O2 via mask. The trachea was subsequently
intubated without the use of hypnotics or muscle relaxants. Anesthesia
was maintained for the cesarean section with 60% N2O and 0.3%
isoflurane in oxygen. A healthy male infant was delivered with Apgar
scores of 7 and 9.

The patient fully recovered from the effects of the spinal anesthet
c in 2 h, and the trachea was extubated without complications. Post-
operatively, she developed a severe post-dural puncture headache,
which was treated with two epidural blood patches and resolved in
1 week.

It was surprising to me that 11.25 mg subarachnoid bupivacaine
produced a total spinal anesthetic in this patient. Indeed, Norris
found that 15 mg hyperbaric subarachnoid bupivacaine provided
adequate anesthesia in parturients presenting within wide ranges of
age, height, weight, body mass index, and vertebral column length.5
Nevertheless, my patient displayed the effects of a massive subarachnoid
overdose of local anesthetic, despite use of a hyperbaric mixture
that was administered while the patient was in the sitting position.
Dose, positioning, and baricity alone would make a total spinal
anesthetic unlikely in this patient.

In this instance, I believe our dose was injected into a relatively
much smaller volume of CSF, leading to a much higher than expected
level. This smaller volume of CSF occurred secondary to the two
unintentional dural punctures produced during attempted epidural
analgesia. The decreased volume of subarachnoid spinal CSF was
potentially due to direct loss of CSF through the dura. Additionally,
a collection of CSF in the epidural space could compress the now
deformable dural sac, resulting in a smaller volume of subarachnoid
spinal CSF and unexpected total spinal anesthesia.

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The Bullard Laryngoscope and Size of the Endotracheal Tube

To the Editor.—The development of an introducing stylet for the
Bullard laryngoscope (BLS) has simplified the procedure of tracheal
intubation. The introducing stylet duplicates the shape of the BLS
blade, and it bends to the left at an approximate angle of 20° near
the distal end of the fiberoptic housing, providing guidance of the
dorotctal tube (ETT) into the trachea. Before attempting intu-
bation, the ETT is “loaded” onto the stylet, which is fastened to the
BLS in its respective slot, bringing the vertical part of the stylet behind
and on the right side of the laryngoscope in the groove formed by
the blade anteriorly and by the lens housing medi
tally. The depth of the groove is only 5 mm, permitting the use of ETTs in sizes ranging
up to 7.5 mm ID without displacing the introducing stylet posteriorly.
This allows the endoscopist to visualize the distal 8 mm of the stylet
through the eyepiece of the BLS and determine whether the stylet’s
tip faces the middle third of the left vocal cord, which is an ideal
position for successful passage of the ETT (fig. 1).

A size 8.0 mm ID ETT will displace the stylet posteriorly because of
its larger diameter. This displacement occurs in such a way that only 1-2 mm of the distal end of the stylet can be viewed through the
eyepiece and the tip of the stylet is usually facing the interary-
tenoid fold (fig. 2). Intubation of the trachea is still possible if care
is taken not to allow the stylet’s tip to drift posteriorly during ad-
vancement of the ETT, which would result in an esophageal intu-
bation.

Larger ETTs (8.5 and 9.0 mm ID) displace the stylet even more
posteriorly, thus losing the benefit of being able to view the tip of

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