

## CORRESPONDENCE

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## Neonatal Resuscitation and Anesthesiologist Liability

*To the Editor:*—Competence in the performance of neonatal resuscitation appears to be an important medicolegal as well as clinical arena for anesthesiologists. A recent issue\* of a publication containing summaries of medical malpractice litigation cases submitted by involved attorneys described a \$2,602,100 judgement against an anesthesiologist for negligent performance of neonatal resuscitation. This case involved a cesarean section performed because of abruptio placentae.

I obtained a list of all obstetric anesthesia-related law cases submitted to that publication since 1985. Of the 69 obstetric anesthesia lawsuit summaries published, 12 (17.4%) involved neonatal resuscitation claims against anesthesia personnel. Issues mentioned included delayed intubation, improper intubation, and failure to initiate neonatal advanced life support. There was a payout to the plaintiff in 10 of the 12 cases (85%).

Although these case summaries are not sophisticated analyses of closed-claims data by a panel of experts,<sup>†</sup> they represent a collection of data that appears to be of considerable interest to trial lawyers—

\* Medical Malpractice Verdicts, Settlements, & Experts. Edited by Laska L. Nashville, 9: No. 11, 35, 1993.

† Guideline VII: Guidelines for Regional Anesthesia in Obstetrics. American Society of Anesthesiologists, Directory of Members, 1994, p 754.

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## Spinal Dysraphism and Epidural Anesthesia

*To the Editor:*—Patients with spinal occult dysraphism have cutaneous stigmata including lumbar lipoma, dermal sinus tract, hemangioma, telangiectasia, abnormal tufts of hair, or lumbar dimple.<sup>1</sup> We examined a patient with occult spinal dysraphism who received epidural anesthesia during delivery and had leg weakness subsequently, although anesthesia was adequate.

A 30-yr-old gravida 1, para 0 woman presented at 37 weeks' gestation for examination. Because of preeclampsia and ruptured membranes, labor was induced with oxytocin. The patient had a medical history of multiple surgical procedures on the lumbar area to remove a giant hairy nevus. She denied prior neurologic dysfunction.

and therefore should be of interest to all anesthesiologists who perform obstetric anesthesia. A suggestion for risk management could be that those anesthesiologists who are routinely expected to perform neonatal resuscitation maintain a reasonable level of skill in that area; however, consideration should be given to ensure that hospital rules and regulations clearly define the anesthesiologist's role in neonatal resuscitation. Those rules and regulations should be compatible with the statements in the American Society of Anesthesiologists "Guidelines for Regional Anesthesia in Obstetrics."<sup>†</sup>

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### Reference

1. Chadwick HS, Posner K, Caplan RA, Ward RJ, Cheney FW: A comparison of obstetric and nonobstetric anesthesia malpractice claims. *ANESTHESIOLOGY* 74:242-249, 1991

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Epidural analgesia was performed when cervical dilation reached 4 cm. An 18-G Tuohy needle was placed with the bevel directed cephalad at the L3-L4 interspace, with the patient in the left lateral position. Neither cerebrospinal fluid nor blood was aspirated. After insertion and advancement of a catheter 4 cm, a test dose of 3 ml 1.5% lidocaine with epinephrine was given without incident followed by an initial dose of 9 ml 2% 2-chloroprocaine. Satisfactory analgesia ensued, with a bilateral T10 sensory level. Thirty minutes later, 11 ml 0.2% bupivacaine followed by an infusion at 13 ml/h was administered. After an additional hour, pelvic pain recurred and 2 µg/ml fentanyl was added to the infusion.