LETTERS TO THE EDITOR

DEAR SIR:

I wish to report a serious complication of ducting anaesthetic gases to atmosphere.

Mr. A.M., an otherwise healthy 60-year-old male, was being anaesthetized for cranioplasty. The anaesthetic was Innovar, nitrous oxide and a tubocurare, and ventilation was being controlled via a semiclosed circle absorber circuit, by means of a Ventimeter Ventilator. The waste anaesthetic gases were being ducted to atmosphere by means of corrugated tubing, from the exhalation valve of the ventilator to the air-exhaust duct in the Operating Room. Part of this exhaust tubing lay on the floor.

During closure of the skull defect the brain began to bulge and venous bleeding increased. The colour of the skin turned blue. The E.C.G. monitor showed marked bradycardia. A glance at the manometer on the soda lime absorber showed high pressures had developed in the circuit. A check of the apparatus showed a wheel of the anaesthetic machine had passed over the corrugated exhaust tubing. Relief of the obstruction prevented a catastrophe and the operation proceeded to a successful conclusion.

By utilizing the exhalation valve of the ventilator for ducting exhaust gases there is grave danger of high pressures developing in the circuit on occlusion of the exhaust tubing.

It is apparent that when this type of scavenging system is used, another "Blow-off" valve should be placed in circuit.

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