tions and the other clinical possibilities, we felt that MRI was not indicated in this case; this was confirmed after discussion with our neurosurgical colleagues.

Although pulsatile bleeding is usually associated with arterial puncture, in the clinical situation of pregnancy and labour in particular, raised intra-abdominal pressure can cause increased venous pressure within the valveless venous plexus of Bateson potentially producing significant haemorrhage. Anaesthetists should be reminded of the potential for damage to these vascular structures, especially in the obstetric patient. Thankfully, it would seem that cases such as ours are rare.

C. Taylor, S. Chitre
Department of Anaesthetics
Whipps Cross University Hospital, London, UK
E-mail address: claretaylor75@doctors.org.uk

References


0959-289X/S - see front matter
© 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.ijoa.2013.03.014

A novel airway checklist for obstetric general anaesthesia

Management of the obstetric patient’s airway is a significant source of anxiety to all anaesthetists as a result of the combined risks of possible difficult intubation, increased susceptibility to hypoxaemia and potential for pulmonary aspiration of gastric contents. A recent innovation in medicine has been the development of clinical checklists for a variety of situations. The main aim is to reduce human error through good preparation and rapid identification of potential difficulties. Using check-

Fig. 1 Airway checklist for obstetric general anaesthesia. EtO₂: end-tidal oxygen fraction; FRC: functional residual capacity; ETT: endotracheal tube; LMA: laryngeal mask airway; RSI: rapid-sequence induction.
lists in acute and non-acute situations has been shown to improve patient safety and outcomes. Moreover, recently, the authors of the fourth National Audit Project review of major complications of airway management recommended that a simple checklist based around preparation of the patient, equipment and drugs, staff and for possible difficulty can identify potential problems in a very short time and improve patient safety.

Against this background we have developed an airway checklist for use in obstetrics. Initially, we surveyed the views of experienced obstetric anaesthetists in our unit to establish which elements of airway management in obstetrics should be included in the checklist. From this, it became clear that it should be divided into three sections: preparation of the patient, preparation of equipment and preparation for difficulty. We designed the checklist to be conducted by the anaesthetist and airway assistant using a challenge-response system.

A series of ‘trial runs’ in a simulator environment have enabled refinements to the checklist through observation of its use in simulated obstetric emergencies that required the administration of a general anaesthetic. We also surveyed the anaesthetists and anaesthetic assistants who used the checklist to ascertain their perception of its use. As a result of this process, we modified the checklist to make it shorter and more focused so that it can be completed during the period of routine pre-oxygenation (Fig. 1). We felt it to be important to include aide-memoires particularly to optimise patient preparation in regard to patient position and pre-oxygenation. Removal of left lateral tilt can improve the view at laryngoscopy although this may be at the expense of worsening aortocaval compression. Studies in the simulator have allayed concerns that using the checklist may delay induction of anaesthesia in category 1 caesarean sections.

We believe that use of our checklist will improve safety and decrease the risk of critical incidents associated with obstetric general anaesthesia. We have introduced it in to practice in our unit and intend to complete a further audit cycle in 2013.

M.D. Wittenberg, D.J.A. Vaughan, D.N. Lucas
Department of Anaesthesia, Northwick Park Hospital
Harrow, Middlesex, UK
E-mail address: mwittenberg@doctors.net.uk

References

Epidural analgesia in a parturient with lumbar tinea versicolor

Local infection may be considered a relative contraindication to epidural catheter placement; however, clinical judgment may allow such techniques to be used in selected cases. We report a case of epidural catheter placement in the presence of lumbar tinea versicolor with no neurological or infectious sequelae.

A 30-year-old nulliparous woman at 39 weeks of gestation presented to our labor and delivery unit for induction of labor secondary to pregnancy-induced hypertension. She was otherwise healthy. The patient was afebrile and had a normal leukocyte count. A diffuse maculopapular rash was noted on the patient’s chest, abdomen, shoulders, and back without evidence of superinfection or excoriation (Fig. 1). She first noted the rash on her chest five years previously and at that time was diagnosed with tinea versicolor. She had treated the lesions unsuccessfully with a variety of regimens including chemical peels, topical selenium sulfide, topical antifungals, topical steroids, and a course of an unknown antibiotic.

The patient requested epidural analgesia, however, there was concern regarding presence of the rash over the lumbar region. The L2-3 and L3-4 interspaces were entirely covered by the rash. The lower border of the rash appeared near the L4-5 interspace. After a thorough discussion with the patient regarding our concern for infection risk, the decision was made to proceed with the epidural analgesia.