

cytes and Gram-negative bacteria. An anaerobe was cultured from the gastric fluid.

It is well known that the amniotic fluid infection syndrome is often associated with premature labor.^{4,5} The purulent gastric aspirate in this case established infection as the probable cause of the premature labor. Moreover, since tocolysis is not indicated⁶ and is indeed dangerous in the presence of amnionitis, the plaintiff's argument was discredited. Placental pathologic examination, should it have been available, would likely have yielded similar information in this case.

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Discoloration of amniotic fluid obtained at amniocentesis

To the Editors:

In the Correspondence section of the JOURNAL Drs. Strickland and Hankins (Strickland DM, Hankins GDV. Amniotic fluid discoloration caused by blood. *AM J OBSTET GYNECOL* 1987;157:216-7) quoted Zorn et al.¹: "Surprisingly, little investigation has been done into the cause of the discoloration. Various authors have assumed it to be blood." At that point Zorn et al. inserted a reference to an article by Hankins et al.² All of these authors should refer to a manuscript published by Golbus and Stephens.³ On page 249 of this article there is a summary of a study done on discolored fluid obtained at genetic amniocentesis, and I quote: "To investigate the cause of discoloration, spectrophotometric analysis was performed on discolored fluids, on clear fluids, and on clear fluids to which either meconium or blood had been added. The discolored fluid had a large 405 to 415 N-M peak shared by both meconium and oxyhemoglobin in addition to peaks 540 and 575 N-M-1. Clear fluid to which blood has been added and which then had been incubated at 37 degrees for twenty-four hours demonstrated both the 540 and 575 N-M peaks seen in the discolored fluid. These later two peaks have been described as being secondary to contamination of amniotic fluid with blood, and

the discoloration appears to be caused by aged blood pigments."

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Some thoughts from the other side of the ether screen

To the Editors:

The anesthesiologist is sometimes faced with a situation in which he induces general anesthesia for cesarean section, administers a muscle relaxant, then cannot intubate the airway. This problem, combined with esophageal intubation and aspiration pneumonitis, which usually concur with difficult intubation, is the most frequent cause of anesthesia-related maternal death.^{1,2} In such a stressful situation the anesthesiologist must act quickly and efficiently to save the mother from the two formidable causes of maternal death: (1) hypoxia because the mother is paralyzed and (2) aspiration because the airway is not protected. In the absence of fetal distress the plan is usually to wake her up and consider either awake intubation or a major regional anesthesia technique, such as spinal or epidural block. However, when the indication for cesarean section has been fetal distress, the decision is more difficult, and physicians do not agree on the line of action. Here I express one point of view and I am willing to listen to others. My primary concern as an anesthesiologist is maternal life. I feel it is unfair to sacrifice one person's life for another person. Therefore, unless specifically indicated by the mother to deliver the baby at all costs, including her life, our attention, as well as our moral and ethical obligation, is to save the mother. An explicit and informed consent must be obtained from the mother, preferably before onset of labor.

It is understood that an ordinary cesarean section or even any surgical procedure carries the risk of death, but that risk is quite evident and is a reality when the mother becomes hypoxic or aspirates gastric contents. On occasion, a few overzealous young obstetricians push for the immediate delivery of a 27-week fetus without consideration of the anesthetic risks to the mother. A scenario can develop that, despite a difficult