

Correspondence

Anesthesiology
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Malignant Hyperthermia during Regional Anesthesia

To the Editor:—I would like to correct a statement made by Dr. Wadhwa that the malignant hyperthermia syndrome has not been previously reported to occur in association with regional anesthesia.¹ We reported a case of a patient who survived one episode of malignant hyperthermia under general anesthesia and who had a somewhat attenuated but otherwise similar episode during subsequent spinal anesthesia.² At least one other case of malignant hyperthermia occurring during local anesthesia has been described, although not documented in detail.³

These case reports, along with that of Dr. Wadhwa, are in support of my general impression that the syndrome of malignant hyperthermia may be triggered by a host of nonspecific stresses in addition to the pharmacologic stimuli that have been identified in the laboratory. Indeed, it has been suggested that anxiety alone may induce an episode of malignant hyperthermia.⁴ Dr. Wadhwa's

point is well taken, "regional techniques . . . are not foolproof."

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More Than V₅ Needed

To the Editor:—Drs. Kaplan and King¹ have properly stressed the importance of lead V₅ of the ECG for detecting the occurrence of myocardial ischemia during anesthesia. While we have been using this for some time in open-heart procedures, a potential danger exists if one assumes no other lead need be monitored. Lead V₅ is expected to evaluate the anterior-lateral surface of the heart effectively, and often shows changes more clearly than leads I or AVL. In contrast, the inferior surface of the heart (supplied to a large extent most often by the right coronary artery) is readily evaluated with a tracing of leads II, III, or AVF,^{2,3} but frequently not with lead V₅.

We want to emphasize this with the attached cardiogram (fig. 1) obtained as a continuous strip from a patient who had a period of myocardial ischemia following cardiopulmonary bypass for valve replacement. No evidence of ST change is evident from the V₅ lead, but all the inferior leads show marked ST elevation. These subsequently improved with continued close supportive care. While V₅ is indeed a valuable monitor, one must not neglect to check other leads frequently, especially leads II, III, and AVF.

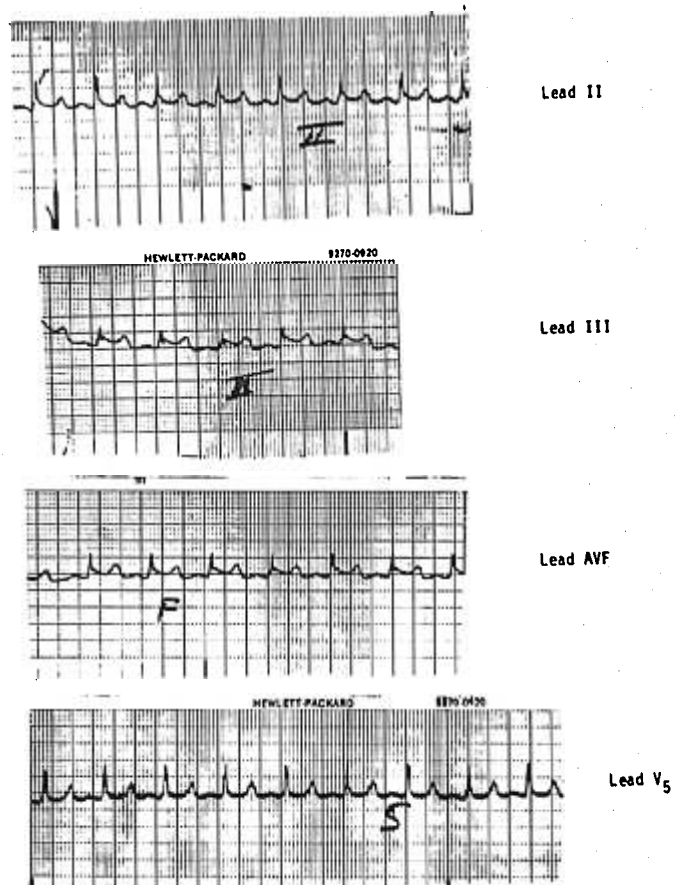


FIG. 1. Cardiogram from patient who had myocardial ischemia after cardiopulmonary bypass.