mechanical factors, and is very uncommon now that we understand how to optimally manage pediatric tracheal intubation. We studied the more transient airway complications—cough, breath-holding, and laryngospasm—which we presume are related to the irritant effects of anesthetic agents and reflex activity in the awakening patient, as well as to any possible mechanical factors (such as airway secretions). We also documented the level of arterial oxygenation that followed extubation. None of our patients suffered laryngeal edema.

All of our patients were managed by the same general methods, and care was taken to select appropriately sized endotracheal tubes using methods described in standard texts. None of the patients was having head and neck surgery, and in none was the airway difficult to intubate; thus, there were no unusual head movements, and repeated attempts at intubation were not required for any patient. All of the patients were positioned supine and were subsequently randomized into the various treatment groups. Thus, we believe that the comparisons that we made between groups were valid.

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Truth in Advertising: The Journal’s Responsibility

To the Editor—Regular perusal of the literature of one’s medical specialty occasionally yields potent irony.

In the April, 1991 edition of ANESTHESIOLOGY, an editorial appeared entitled “Ethics in Publishing,” co-authored by the editors-in-chief of four of the world’s preeminent anesthesiology journals. The views expressed in the editorial are laudable and include such issues as submission to various journals of research papers containing previously published data, use of identical control data in two papers, and violation of ethical standards involving human experimentation.

Passing reference also was made to the problem of financial conflicts of interest in publishing. Ironically, appearing within several pages of advertising copy immediately preceding this editorial is a six-page, full-color advertisement for a new agent from Glaxo Pharmaceuticals called Zofran (ondansetron HCl). This agent is touted as a “shining breakthrough for the control of emesis” (certainly an area of interest to anesthesiologists); reading on, however, one finds the qualifier “induced by cancer chemotherapy”. Glancing at the “fine print” in the product summary, one confirms that this agent is approved by the Food and Drug Administration solely for the control of emesis due to such chemotherapeutic regimens. Why, then, publish such advertising in ANESTHESIOLOGY?

The answer becomes apparent when one considers that, coinciding with the publication of this advertisement, Glaxo’s sales representatives began “detailing” anesthesiologists, including myself, on the merits of this agent. Its cost, it should be noted, is staggering—roughly $40–50 per dose. Such expense is only justified when an agent offers an exceptional advantage over currently available therapies.

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In Reply—Clearly, medical journals, including ANESTHESIOLOGY, are not constituted to conduct scientific peer review of or to act as a Food and Drug Administration (FDA) for advertisements. As recently stated, “An ad is an ad,” and this Journal believes its readers are able to distinguish between advertisements and peer-reviewed articles. Furthermore, our faith in our readers extends to their ability to assess the cost/benefit of new drugs advertised either in the Journal or directly by sales representatives.

It is also important to note that once a drug is available for a single indication, its use may be extended into other areas. For instance, the use of ondansetron has now been reported to be effective in postsurgical nausea. These clinical extensions are important to medicine because drug companies often do not go to the expense of certifying drugs for all acceptable indications. For example, epidural use of fentanyl is not an indication approved by the FDA but is in widespread practice by anesthesiologists.

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A New Presentation of Post–Dural Puncture Complication

To the Editor—Post-dural puncture headache is a frequent complication of spinal anesthesia and lumbar puncture. We report a case of a new presentation of a post-dural puncture complication.

A 27-yr-old man developed acute headache, fever, and chills. He came to our emergency room, where diagnostic procedures, including lumbar puncture (LP), were performed. The LP was performed at L3–L4 or L4–L5. A 20-G Quincke-Babcock spinal needle was used. The procedure was atraumatic. All studies including cerebrospinal fluid chemistries and cultures were within normal limits. His original symptoms resolved over the next day. The patient was presumed to have a viral illness.

However, on the 3rd post-LP day the patient experienced sharp shooting pains down the medial aspect of both arms and into the wrists and fingers without associated headache, auditory, or visual disorders. The pains were postural, resolving completely with assumption of the supine position but recurring with the sitting or standing position. Neurologic examination revealed no sensory or motor deficits. The pain appeared to be in the distribution of the sixth, seventh, and eighth cervical dermatomes. The working diagnosis was a new presentation of post-dural puncture complication. An epidural blood patch was performed at the level of the previous LP with 15 ml autologous blood. The patient's symptoms immediately resolved. He was able to assume the sitting or standing position completely without pain. He did complain of slight low back pain for 1 day. At 6 weeks follow-up, the patient had no back pain and no recurrence of the arm pain.

Neurologic sequelae from spinal anesthesia have drawn much attention over the years. Vandam and Dripps reported 71 cases (0.8%) of sensory neurologic symptoms and/or signs after a spinal anesthetic. Phillips et al., in their series of 10,440 spinal anesthetics with lidocaine, reported 38 patients with peripheral nerve symptoms; in 8 patients the symptoms persisted after discharge from the hospital. Neither series demonstrated major central nervous system sequelae. Possible etiologies for these neurologic deficits include spinal cord ischemia, chemical contamination of local anesthetic solutions, local anesthetic solutions themselves, and traumatic insertion of spinal needle. None of these seemed plausible in our case. Our patient was hemodynamically stable, received no intrathecal local anesthetic, and had an atraumatic LP.

Epidural blood patch remains the gold standard treatment against which other treatment regimens for post-dural puncture complications are measured. That our patient’s symptoms were relieved by a blood patch suggests that his symptoms were at least in part related to decreased pressure in the subarachnoid space. Despite an extensive review of the literature, we were not able to find a report of postural paresthesias associated with lumbar puncture.†‡

Our patient’s pain appeared in the dermatomes corresponding to the sixth, seventh, and eighth cervical nerves. We believe that the pain may have been caused by traction on the lower cervical nerve roots where they exit through the intervertebral foramen, due to decreased pressure in the subarachnoid space. It is theorized that with leakage of cerebrospinal fluid there is descent of the brain in the upright position. The spinal cord (and consequently the cervical nerve roots) also may descend, resulting in traction on the cervical nerve roots. This traction would be greatest in the sitting or standing position because these positions create a pressure differential in the subarachnoid and epidural spaces that favors leakage of cerebrospinal fluid and descent of the spinal cord and cervical nerve roots. Although the actual etiology and mechanisms of this patient’s postural paresthesias remain unclear, we believe that traction on the lower cervical nerve roots secondary to decreased subarachnoid pressure is certainly possible.

In summary, we report what we believe to be an atypical presentation of a post-dural puncture complication.

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