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Postoperative Acetaminophen and Warfarin. Undesirable Combination

To The Editor:—Warfarin anticoagulant used commonly; hence, the physician dealing with patients with chronic pain can expect to encounter patients taking these drugs and almost certainly will be involved in prescribing analgesic medications for such patients. Pain practitioners, therefore, should be particularly aware of the recent article published by Hylek *et al.*¹ and the accompanying editorial by Bell.² These articles showed that acetaminophen interacts with warfarin in an unknown fashion to substantially augment the degree of anticoagulation. This phenomena occurs gradually with long-term therapy. In this article, it has been shown that acetaminophen dosage from 2,275 mg to 4,549 mg per week (1 to 2 tablets of Vicodin [USP] or Lortab [UCB Pharma, Inc., Smyrna, GA] per day for 1 week) can increase the odds of having an international normalization ratio more than 6 from 3.5- to 6.5-fold. A further escalation of the dose to 9,100 mg acetaminophen or more per week (3-4 tablets of Vicodin or Lortab per day for 1 week) will increase this risk by 10-fold.

Acetaminophen intake in patients prescribed a stable warfarin dosage might increase the international normalization ratio within 18 to

48 h.² Hylek *et al.*² found that a potentiating effect was detected after 7 days and peaked by 12.5 days after acetaminophen intake.² Physicians should carefully consider prescribing acetaminophen-containing drugs in patients prescribed warfarin. It is especially important that physicians specializing in pain management be aware of this situation.

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Severe Anaphylactic Reaction Due to a Chlorhexidine- impregnated Central Venous Catheter

To the Editor:—We read with interest a case report by Oda *et al.*,¹ which appeared in a recent issue of ANESTHESIOLOGY. We also encountered a patient, a 28-yr-old man, in whom anaphylactic shock developed twice during anesthesia. He was scheduled to undergo surgery for traumatic brachial nerve palsy. Medical history was limited to allergic rhinitis. Atropine, hydroxyzine, and cefazopran hydrochloride were administered 1 h before the anesthesia. The induction of anesthesia and tracheal intubation was performed uneventfully using thiopental, fentanyl, and vecuronium, and maintained with nitric oxide (N₂O), oxygen (O₂) and isoflurane. A few minutes after the insertion of a central venous catheter impregnated with chlorhexidine and silver sulfadiazine (Arrow gard⁺ Blue, Arrow International Inc., Reading, PA), we noticed hypotension (from 115/45 mmHg to 45/28 mmHg), tachycardia (85 beats/min to 125 beats/min), fall of pulse oximetry (SpO₂)

(from 98% to 79%) and end-tidal pressure of carbon dioxide (PET_{CO₂}) (from 35 to 6 mmHg), and skin erythema in his upper body. During resuscitation, his carotid artery pulse was palpable. With administration of ephedrine, lactated Ringer's solution and adrenaline, blood pressure was restored to 118/40 mmHg in 1 h. The surgery was postponed. The central venous catheter was withdrawn the next afternoon. Lymphocyte transformation test was performed for cefazopran hydrochloride, vecuronium, and thiopental. Only cefazopran hydrochloride appeared to be strong-positive (+++).

Four weeks later, his second surgery was scheduled. An arterial line was placed after lidocaine infiltrated locally. Induction of anesthesia and tracheal intubation were performed using midazolam, buprenorphine, ketamine, and vecuronium. Soon after the insertion of a chlorhexidine- and silver sulfadiazine-impregnated catheter (Arrow gard⁺