CORRESPONDENCE

References


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In Reply.—We would like to thank Dr. Youngs for her interest in our article. Her comments highlight some important points regarding the etiology of transient neurologic symptoms (TNS). Intrahepatic lidocaine has a long history of use without reports of TNS. Potential systematic changes that have occurred in the early 1990s may be responsible for the reports that appeared at this time. Several possibilities include the following: heightened awareness on the part of anesthesiologists to subtle clinical symptoms in their patients, early ambulation of patients who have been administered a spinal anesthetic, and finally, as Dr. Youngs points out, the use of small-gauge, pencil-point needles with side ports.

We agree with Dr. Youngs' comments that a slow injection of a hyperbaric solution may lead to pooling of the anesthetic and a mal-distribution of local anesthetic concentration within the cerebrospinal fluid. However, in our study, we used isobaric solutions of mepivacaine and lidocaine. It is unclear whether the aforementioned mechanism for maldistribution applies to isobaric preparations. It is clear from the many studies looking at the incidence of TNS after spinal anesthesia with lidocaine that this syndrome occurs comparably when isobaric and hyperbaric solutions are used.

In Reply.—We appreciate the interest in our article expressed by Dr. Youngs. Unfortunately we did not measure in the study the speed of injection. The cause of transient neurologic symptoms is still unknown. The idea that the mal-distribution of local anesthetic can be affected by the injection speed with the use of pencil-point needles cannot be ignored. However, Holman et al., in a recent study in a spinal cord model, concluded that, at clinically relevant rates of injection, needle characteristics minimally affect solution distribution.

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