degree of antibacterial activity. We are worried that this may encourage anaesthetists to adopt this practice, because the addition of lidocaine to propofol seems to increase the incidence of adverse reactions.

Evaluation of unpublished data from the National Adverse Reaction Consultancy Service (NARCOS) indicates that there is a higher incidence of cardiovascular reactions when propofol is mixed with lidocaine than when these drugs are administered separately (Table 1).

Table 1 Data of life-threatening reactions (grade III–IV), collected by NARCOS during 1994–1996

<table>
<thead>
<tr>
<th>Drug</th>
<th>No. of reported reactions</th>
<th>Predominant symptoms in grade III–IV reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propofol</td>
<td>64</td>
<td>46 — bronchospasm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 — cardiovascular</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 — bronchospasm + cardiovascular</td>
</tr>
<tr>
<td>Propofol + lidocaine</td>
<td>23</td>
<td>5 — bronchospasm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 — cardiovascular</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 — bronchospasm + cardiovascular</td>
</tr>
</tbody>
</table>

The mechanism of these adverse reactions is not known but may involve aggregate or micelle formation, which can occur when propofol and lidocaine are mixed. Some data suggest that there are fewer life-threatening reactions to anaesthetic agents in France than in the UK (1 in 9000 vs 1 in 5000 anaesthetics, respectively). This could be because of the different practice of i.v. drug administration on induction of anaesthesia in France, where injection of these drugs into a fast-flowing saline drip is commonplace.

We would recommend that anaesthetists should be aware of the importance of these drug interactions and should be trained never to mix drugs, to flush i.v. lines/cannulae with saline between administration of every drug and to concentrate on an aseptic technique of drug administration.

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Editor,—Drs Wild, Shinde and Newton express the concern that mixing propofol and lidocaine leads to a higher incidence of bronchospasm and cardiovascular reactions than if given separately, and present a table from the National Adverse Reaction Consultancy Service to support this claim.

Unfortunately, they have either provided incomplete data or have drawn the wrong conclusion from these data. They present almost three times as many reported life-threatening reactions from using propofol alone than from using the combination. It would help to know the total number of patients receiving each, as they do not inform us if the combination is more prevalent, equally prevalent or less prevalent than the use of propofol alone among practising anaesthetists. More importantly, they do not inform us what percentage of the whole these values represent to allow us to obtain the ‘full picture’ and share their concern. Given the very large total numbers of patients involved, these small numbers, and that fact that more than 75% are in the propofol alone group, make meaningful interpretation impossible. I can only restate that I personally have been using the combination for more than 5 yr and to my knowledge have not had a major life-threatening event attributable to the combination.

It is exactly because, in my opinion, anaesthetic and ICU drug administration is completely lacking in aseptic technique that I thought of the idea of studying the mixture of a potential contaminant (propofol) with an antibiotic (lidocaine), and my colleagues share the same concern.

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**Avoiding movement at laryngeal mask airway insertion**

Editor,—Having read the interesting article by Doi and colleagues on prediction of movement at laryngeal mask airway (LMA) insertion, I would like to make a comment and a suggestion. My comment is about this, and another recent article, on using ‘loss of the eyelash reflex’ as a useful end-point for judging when to insert a laryngeal mask. Loss of the eyelash reflex, according to Guedel’s stages of anaesthesia, signifies the end of stage 1 (analgesia) and heralds the arrival of stage 2 (excitement). This clinical sign is often used to confirm that consciousness has been lost, although loss of verbal contact is a better end-point when using propofol as the induction agent.1–3

To avoid coughing, movement or difficulty with jaw relaxation, I suggest that a face mask is sealed over the patient’s airway as soon as the eyes close and they appear to be losing consciousness. If the LMA is inserted as apnoea occurs (accurately identified by diminishing, then absent bag movement) the manoeuvre is usually smooth.

2 Ring J, Messmer K. Incidence and severity of anaphylactoid reactions to colloid volume substitutes. Lancet 1997; i: 466–8
The period of time to apnoea varies according to the dose, speed of administration and the patient’s pharmacodynamic and pharmacokinetic response to propofol. Apnoea may not occur, intentionally or not, if a modest dose is given slowly. If so, LMA insertion is smoother if depth of anaesthesia is increased first using either a potent inhalation agent or a further propofol bolus.

While teaching and observing junior colleagues, I have noticed that unsuccessful or less smooth LMA insertion occurs more often when attempted before apnoea has occurred. Are we sometimes a bit hasty?

J. Nanson
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Editor,—Thank you for the opportunity to reply to Dr Nanson. We reported in a previous publication¹ that, in a total of 38 transitions from the conscious to the unconscious state using propofol, the eyelash reflex was lost simultaneously with the response to command in 22% of patients, response to command was lost first in 39%, and the eyelash reflex was lost first in 39%. Therefore, in approximately 40% of patients, response to command may be retained when the eyelash reflex has been lost.

Clearly, loss of the eyelash reflex may not indicate accurately loss of consciousness and we would agree completely with the view that loss of the eyelash reflex does not indicate sufficient depth of anaesthesia to permit insertion of a laryngeal mask airway. We used the loss of eyelash reflex together with confirmation of loss of command to indicate that anaesthesia had been induced. However, as we stated in our article, adequate jaw relaxation was the determining feature for the anaesthetist to consider insertion of the LMA.

We agree absolutely with the final comment that anaesthetists can sometimes be too hasty. We all wish to have end-points reached rapidly and an essential feature of a good anaesthetist is patience.

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