Prostaglandin inhibitors and suxamethonium-induced myalgia

Sir,—In their recent article in the British Journal of Anaesthesia, Dr Kahraman and his colleagues [1] did not quote our original work on the hypothesis that pretreatment with prostaglandin synthesis inhibitors might reduce the severity of suxamethonium-induced myalgia. We demonstrated that use of lysine acetylsalicylate 13 mg kg\(^{-1}\) i.v. 3 min before the administration of suxamethonium reduced the incidence and intensity of suxamethonium-induced myalgia [2]. Similarly, Dr Kahraman and his colleagues showed that diclofenac (an inhibitor of prostaglandin synthesis) 70 mg i.m. in the gluteal muscle 20 min before operation significantly reduced the incidence and intensity of suxamethonium-induced myalgia [1].

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Haemostasis and thrombelastography

Sir,—Further to the reply of authors Mallett and Cox [1] to our Letter to the Editor [2], we were disappointed to note that, in their response, reference was made incorrectly to published studies from this unit [3] and elsewhere [4] in support of their claim that thrombelastography (TEG) has a high specificity for the detection of postoperative bleeding in adult cardiac surgical patients [5].

We wish to correct their error in making this claim, as both of these original articles demonstrated no predictive value of TEG monitoring for subsequent haemorrhage after adult open-heart surgery.

We trust that this clarification will remove any confusion which may arise in readers of this interchange.

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Arterial spasm after administration of diazepam

Sir,—The complications which occur after i.v. administration of diazepam dissolved in propylene glycol (Valium) are well known, and include pain, redness, swelling and thrombophlebitis [1]. To our knowledge, arterial spasm secondary to i.v. injection of diazepam has not been described previously.

A 31-yr-old primipara underwent elective Caesarean section. General anaesthesia was induced with thiopentone 5 mg kg\(^{-1}\) and vecuronium 1 mg kg\(^{-1}\) via a vein located on the lateral aspect of the radial side of the right wrist. The cannula was well placed and there was no extravasation of drugs. In the recovery room, the patient was restless and diazepam 10 mg was injected into the same vein. The injection was painful and a few minutes later, venous spasm occurred and the hand and wrist became cyanotic and oedematous. One percent lignocaine 50 mg was injected into the vein a few centimetres above the spasm, but no effect was observed. Five minutes later, the radial arterial pulse was no longer palpable and the hand was white and cold, with pachy blue discolouration. One percent lignocaine 100 mg with heparin 5000 iu was injected i.a. via the axillary artery. A few minutes later, the radial arterial pulse was palpable and gradually the hand and wrist became warmer and less cyanotic. The next day the radial and ulnar pulses were palpable, but the wrist was slightly oedematous. There was no sensory loss, but movement of the thumb was painful.

There have been various reports of i.a. injection of diazepam with tissue damage resulting in loss of digits or even limbs [2, 3]. In our patient, the diazepam was injected i.v., but the injection was made in the arm which had a pressure cuff (Datex) attached for automatic measurement of arterial pressure. It is most probable that the injection was made whilst the cuff was inflated. Increased pressure in the arm of the patient probably caused extravasation of diazepam out of the vein and into the radial artery; the arterial spasm was probably associated with a partial compartment syndrome [4].

Local complications of parenteral diazepam or other lipid-soluble drugs may possibly be avoided by slow injection of diluted material. Care should be taken to ensure that injection is not made while the arterial pressure cuff is inflated.

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Inflation of the tracheal tube cuff as an aid to blind nasotracheal intubation

Sir,—In the article by Van Elsnaet and colleagues [1], the authors did not specify the type of tracheal tube used. I used Gorback’s technique [2] with success in 12 of 13 patients (eight on the first attempt) using prewarmed lubricated nasal RAE tubes (Mallinkrodt Laboratories) in patients aged 12–64 yr, five of whom had a fractured mandible. I attached a capnograph to the tracheal tube and, after inflating the cuff in the nasopharynx, advanced the tube until resistance was encountered. Pressure applied to the sternum or gentle inflation of the lungs elicits an expired carbon dioxide waveform if the tracheal tube is correctly aligned with the laryngeal inlet. The cuff is then deflated as the tube is advanced through the laryngeal inlet.

The unsuccessful episode occurred early in this series, was abandoned after the second attempt and, in retrospect, was probably caused by inexperience with the technique.

Ventilation was easily accomplished in these patients if the tube was aligned correctly in the pharynx and this “nasal laryngeal mask” technique may be worth consideration in a patient with