more easily combined through meta-analyses to provide evidence from several studies in systematic reviews. Finally, this study might be considered sufficiently large to justify the use of parametric tests to compare the summary outcome measures.

The Visual Analogue Scale was not employed in this study and therefore parametric analysis was not employed.

J. J. Nightingale*
B. Higgins
Portsmouth, UK
*E-mail: jeremy.nightingale@porthosp.nhs.uk

Role of dantrolene in the management of the acute toxic effects of Ecstasy (MDMA)

Editor—The use of dantrolene in the management of hyperthermia for acute ‘Ecstasy’ (3,4-methylenedioxymetamphetamine, MDMA) toxicity has been recently reviewed by Hall and Hendry.1 We would like to confirm the efficacy of dantrolene after a recent case that presented to our emergency department.

A 21-yr-old male presented after collapse with, GCS 4/15, generalized rigidity, tachycardia (160 min⁻¹), hypertension (170/120 mm Hg), tachypnoea (40 min⁻¹), and hyperthermia 41.7°C. The history confirmed Ecstasy ingestion. Initial treatment involved physical methods to cool the patient, such as cold i.v. fluids and ice packs. Diazepam 10 mg i.v. and acetaminophen 1 g p.r. were administered. For the following 45 min, the patient’s clinical state failed to improve. After this time, the anaesthetist present gave 1 mg kg⁻¹ dantrolene and almost immediately the patient’s rigidity reduced. Serial measurement of body temperature after dantrolene administration revealed a reduction in core temperature to 38.7 after 30 min and this continued to decrease until it was within normal limits at 90 min. The patient was subsequently transferred to ITU where he was treated supportively for 4 days. He was then discharged to the ward having made a full recovery.

We concur with the recommendation that dantrolene is an effective treatment for hyperthermia due to MDMA ingestion. Its early use in our case appears to have been instrumental in controlling this patient’s hyperthermia.

J. Moon*
J. Cros
Hemel Hempstead, UK
*E-mail: jamesmoon@doctors.org.uk

Fastrach™ tubes: modifying the design for use with the LMA CTrach™?

Editor—I would like to congratulate Liu and colleagues1 2 and Timmermann and colleagues3 on their informative articles critically analysing the LMA CTrach™. I would like to point out that despite the significant improvements of the CTrach™ over the LMA Fastrach™, especially in the ability to observe the tracheal tube passing through the glottis, the manufacturer seems to have failed to make appropriate changes to the design of the Fastrach™ tracheal tubes. In particular, the Fastrach™ tube has no markings to assist the operator performing the intubation to correctly position the tracheal tube below the glottis. The majority of tracheal tubes currently available have either one or two black lines as intubating guides approximately 2–3 cm proximal to the tracheal tube cuff. These marks should be placed at the level of the glottis to avoid both endobronchial intubation and the tracheal tube cuff being too close to the glottis where it may cause inadvertent damage or partial extubation. The importance of these intubation guides was reviewed in a recent paper.4

To assess the importance of intubation marks on the insertion of a Fastrach™ tracheal tube, I have taken two figures from the LCD viewer of the CTrach™ while intubating a manikin. Figure 1 shows the tracheal tube without a mark passing through the glottis. In comparison, Figure 2 shows the same tube with an intubation guide mark drawn with a permanent marker at 3 cm proximal to the tracheal tube cuff. This mark assists an operator placing the tracheal tube to an appropriate depth within

Fig 1 Fastrach™ tube without intubation guide mark.
When using the LMA Fastrach™ tube with an intubation guide mark drawn on the posterior surface of the tube so it may be observed via the CCD camera in the bowl of the LMA by the operator as the tube is being inserted through the glottis.

K. B. Greenland
Brisbane, Australia
E-mail: french9a@yahoo.co.uk

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