stressed by the HVF and had difficulty cooperating. We therefore planned to intubate the trachea with AWS after the induction of general anaesthesia. After setting up alternative devices to secure the airway, including equipment for percutaneous tracheostomy and transtracheal jet ventilator, general anaesthesia was induced. To evaluate C-spine immobility and navigate the manipulation of the AWS, we fluoroscopically observed intubation with a mobile image intensifier. The time taken to complete intubation was 125 s and oxygen saturation did not decrease below 98%. During intubation, alignment of C-spine was maintained in the HVF (Fig. 1).

HVF is the most rigid, established procedure for preventing neurological deterioration in an unstable cervical spine. However, HVF makes alignment of the oral, pharyngeal, and tracheal axes impossible. Fibroscopic bronchoscopy (FB) is recommended for intubation in non-emergency settings. Additionally, case reports show several devices, such as intubating laryngeal mask airway, combitube, Bullard laryngoscope, and retrograde tracheal intubation, were useful for airway management in patients in an HVF.

We recently reported that AWS reduced C-spine movement during intubation in the patient with in-line stabilization. In that study, however, AWS still required the median cumulative upper C-spine movement of 13.5°. Although the alignment of C-spine was kept rigid by HVF in this patient, the shape of AWS allowed for the squeezing of the soft tissue around the glottis to intubate without impact on the alignment of the C-spine.

Manipulation of the AWS is not free from limitation by HVF and it might have resulted in the increased time of intubation (125 s). Adequate oxygenation remains a considerable concern in this method. Another concern is the possibility of aspiration. More than 20 h fasting cannot ensure gastric emptying in this clinical situation. Therefore, care must be taken in extrapolating this case report to other clinical situations. For patients who can accept and cooperate in awake FB, there is no significant benefit in intubation after general anaesthesia. This alternative method could be suitable for patients who refuse or cannot tolerate awake FB. We conclude that the AWS can be an effective option for intubation in patients with HVF.

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Weight loss and 2,4-dinitrophenol poisoning

Editor—There are only a few cases in the literature of 2,4-dinitrophenol (DNP) poisoning in adults resulting in death. We describe the first case of multiorgan failure and widespread rigidity secondary to DNP poisoning 8 h after presentation.

The prevalence of non-prescription weight loss measures is increasing. The internet is commonly being used as a low cost alternative of acquiring advice and prescriptions. DNP (C₆H₄N₂O₅) first gained popularity for weight loss in the 1930s with studies showing that a daily dose of 300–400 mg for 2 weeks resulted in 36–95% increase in an individual’s basal metabolic rate. It was soon taken off the market due to adverse effects including cataracts, liver failure, agranulocytosis, and death. DNP...
has also been used as a herbicide and also as a photographic developing chemical. Its use has now resurfaced via the internet.

A 27-yr-old lady was admitted to accident and emergency complaining of fatigue, nausea, and excessive sweating. She admitted to starting a new diet tablet (bought over the internet) a week before her admission. She had doubled the recommended dose for faster results. Past medical history was negative. She was a non-smoker, non-drinker, and had no known allergies. Initial examination revealed an agitated overweight female (BMI 33) with a GCS of 15. Her airway was clear, respiratory rate (RR) 60, oxygen saturation 100% (FiO₂ 40%), blood pressure (BP) 122/86, and heart rate 140 beats min⁻¹. Temperature was 38°C. There were no other significant clinical findings.

Toxbase was consulted and she received 2 litre of normal saline i.v. over 2 h and diazepam 35 mg orally. Initial arterial blood gas revealed pH 7.46, normal saline i.v. over 2 h and diazepam 35 mg orally. Clinical findings.

Temperature was 38.8°C described. By inhibiting calcium release from the sarcoplasmic reticulum, dantrolene reduces intracellular calcium. This is thought to help to facilitate heat dissipation in uncontrolled DNP-related hyperthermia. We stress importance of early aggressive supportive care and level 2 involvement in cases of DNP poisoning. We also propose the early use of dantrolene.

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Interaction between clonidine and escitalopram

Editor—We report a significant interaction between clonidine and escitalopram in a 66-yr-old critically ill patient. Clonidine was started because of the combination of hypertension and agitation. A few hours later, the patient was calmer and her arterial pressure had decreased to a normal value. The next day, her general practitioner (GP) was contacted to ensure all her regular medication was correctly prescribed. The GP informed us that the patient had been treated for depression with escitalopram for the past year, and this was restarted at a dose of 5 mg. Over the following 3 days, the patient became progressively more drowsy and ultimately almost unconscious. An interaction between the two drugs was suspected and the escitalopram stopped. The following morning the patient was awake and continued to stay alert.

A literature search failed to show any interactions between these two drugs, but one was found with a similar drug, citalopram. This article showed that long-term treatment of rats with citalopram, among other antidepressants, caused a significant decrease in cerebral cortical binding of clonidine accompanied by a functional hyposensitivity of α₂ adrenergic receptors. This led to attenuation of several central effects of clonidine such as hypothermia and sedation. This is the opposite of what we saw in our

3 Tainter ML, Cuttin WC. Febrile respiratory and some other actions of dinitrophenol. J Pharm Exp Ther 1933; 48: 410–29
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