test), but tolerated the semi-synthetic analogue: nalbuphine (in vivo administration). Although meperidine can cause pseudo-allergic reaction, therefore ‘false’ positive prick tests, our patient’s strong skin reaction compared with control persons indicated a true hypersensitivity (Fig. 1).

The case demonstrates the importance of drug allergy examinations in perioperative anaphylaxis and the existence of rare fentanyl and propofol induced severe reactions. Our patient’s case was further complicated by the patient’s hypersensitivity to the non-barbiturate-type sedative propofol, which likely contributed to the onset of anaphylaxis during anaesthesia. Patients who experience perioperative anaphylaxis need a thorough examination for drug allergy. The evaluation should include a precise clinical history, consideration of risk factors, and in vitro and in vivo drug allergy tests.

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None declared.

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Intraoperative transoesophageal echocardiographic detection of a retained surgical sponge

Editor—We report a case where a retained surgical sponge after aortic valve replacement was detected using intraoperative transoesophageal echocardiography having allowed immediate diagnosis and its removal.

A 66-yr-old patient was admitted for aortic valve replacement. He had a long history of aortic stenosis and regurgitation. Preoperative angiography showed a 40% left ventricular ejection fraction and an enlargement of the left ventricular cavity. Coronary angiogram was normal. Anaesthesia was

6 Hepner DL. Anaphylaxis during the perioperative period. *Anesth Analg* 2003; 97: 1381–95

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induced and maintained with sufentanil and propofol. Transoesophageal echocardiography (TOE) performed before cardio pulmonary bypass (CPB) did not reveal any other abnormality. After institution of CPB, the aortic valve was removed and a 21 aortic ATS open pivot bileaflet prosthesis was implanted. Despite usual care (i.e. fluid adjustment, inotrope use), weaning the patient from CPB could not be achieved. TOE examination revealed a mass inside the left ventricle, moving freely with each heart beat (Fig. 1). The presence of a sponge, which could have been placed and not removed in the left ventricular cavity during decalcification of the valve, was detected. CPB was resumed and the surgeon removed the retained sponge. The patient was weaned from CPB without difficulty. He underwent a full recovery and was discharged from the hospital 8 days after surgery.

Retained foreign bodies after surgery are a concern for surgeons. Anaesthetists are not usually directly involved in this problem apart from the induced prolonged duration of surgery or the need for re-intervention (69% in one study). Conversely, intracardiac foreign bodies are extremely rare after cardiac surgery and the anaesthetist can play a crucial role by detecting the problem, in real time.

The use of TOE in cardiac surgery is not routine in many centres or it is used selectively and such an intraoperative diagnosis could have been missed. Recent published guidelines for perioperative TOE state that ‘For adult patients without contraindications, TOE should be used in all open heart (e.g. valvular procedures) and thoracic aortic surgical procedures’. Under these circumstances, this complication could not go unnoticed.

**Conflict of interest**

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