CORRESPONDENCE

Our results suggest that the use of a 29-gauge needle for spinal anaesthesia in young patients using a 29-gauge needle: technical considerations and an evaluation of postoperative complaints compared with general anaesthesia. British Journal of Anaesthesia 1990; 64: 178-182.


EMLA: COMPLICATIONS

Sir,—I was interested to read the letter from Norman and Jones reporting complications with the use of EMLA [1]. Recently, an 8-yr-old boy weighing 25 kg presented for squint surgery. He had a mild history of asthma, not requiring medication, and was otherwise fit. Premedication was with trimetrazine 3 mg kg⁻¹ and atropine 1 mg given orally, and EMLA cream was applied to the dorsum of both hands. According to his mother, a trained nurse, he became somewhat disoriented after about 20 min, pulled off the plastic dressing and licked the EMLA off the back of one hand. Within minutes he blacked out for about 10-15 s, then recovered without any apparent ill-effect. There were no seizures. Unfortunately, the story is uncorroborated as no ward staff witnessed the event. All subsequent clinical observations were normal.

Seizures following ingestion of viscous lignocaine have been reported in children [2,3], and it has been recommended that the total single dose should not exceed 5 mg kg⁻¹. In this instance, approximately one 5-g tube was ingested, equivalent to lignocaine 125 mg and prilocaine 125 mg. If this had been swallowed, it is unlikely that toxic blood concentrations (5-10 μg ml⁻¹) would have been achieved, as first-pass metabolism in the liver results in about 35% bioavailability. It is possible, however, that there was rapid absorption of lignocaine from the oral mucosa, producing a blood concentration sufficient to cause transient bradycardia or other disturbance of rhythm. There may be other theories, but it would seem prudent to take steps to prevent small children removing the adhesive dressing that is applied over EMLA.

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REFERENCES


AN INTERNATIONAL CONSENSUS ON MONITORING

Sir,—The Board of Faculty of Anaesthetists, Royal Australasian College of Surgeons were interested to read the recent Editorial [1]. We were dismayed to note that there was no reference to our Policy Document P18 (1988) on Monitoring for Anaesthesia, and therefore the views of the Australian standards were incomplete. The Faculty standard is that all recommendations in the document needed to be in place by January 1, 1990, and in particular that there should be:

(1) An oxygen supply failure alarm fitted to the anaesthetic machine.
(2) An oxygen analyser in continuous operation.
(3) A pulse oximeter exclusively available for each anaesthetized patient.
(4) A disconnect alarm in continuous operation when an automatic ventilator is in use.
(5) An electrocardiograph, temperature monitor, and carbon dioxide monitor available for every anaesthetic patient.
(6) A neuromuscular function monitor available where clinically indicated.

The Faculty is currently revising this Policy Document and it is highly likely that the new Policy will require increased monitoring standards, particularly for capnography.

The Board of Faculty would endorse the Editorial comments on ergonomic considerations which must be taken into account when considering patient safety. Distraction by monitors must not be permitted to interfere with the proper observation and management of the anaesthetized patient.

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REFERENCE


Sir,—We are sorry that we failed to include the important initiative of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and we are grateful to Professor Baker for highlighting the main recommendations.

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