were other comments about pain relief, one that a patient found it difficult to give their own pain relief, another that the patient was told not to use too much morphine. One complaint involved an inter-relative dispute. The final two comments were about excessive noise.

All of these comments were discussed where appropriate and remedial measures taken if necessary. Patients were written to when their name and address had been supplied.

Only 71 letters had the tick box completed about the usefulness of the visit, the majority of the patients (67) found it of value. The low response rate may reflect the design of the letter, with the question appearing under the signature. Future versions will have the question displayed more prominently.

‘Customer satisfaction’ surveys are common in many consumer industries. We are unaware of any routine survey of this type in patients after admission to an ICU. Inviting comments, rather than waiting for a complaint, does seem to be better. Patients might not make comments unless invited to do so and the improvements these make missed. It also defuses any problems early on, possibly preventing difficulties escalating into formal complaints. During the time of this survey there were no complaints made to the Patient Advice and Liaison Service.

The cost of this type of survey is very small and most patients comment positively on the care they received. This is passed on to the staff. The other comments are also invaluable as they help the ICU to improve.

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1 Park GR, McElligot M, Torres C. Outreach critical care—cash for no questions? Br J Anaesth 2003; 90: 700–1
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‘Gas off’ or ‘vaporizer off’

Editor—It is a common misconception that turning off the vaporizer while leaving the fresh gas flow (FGF) on, during endotracheal intubation, prevents pollution of the anaesthetic room by inhalational agents.

After switching off the vaporizer but leaving the FGF running, it would take four times the time constant to eliminate all the volatile agent from the circuit. Therefore, with the vaporizer turned off, and despite the usually brief time taken to intubate, anaesthetic gases still leak into the atmosphere all the time during intubation if the FGF is left on.

We suggest that the vaporizer setting be left where it is but the FGF be turned off during intubation. This practice would completely eliminate the discharge of the anaesthetic gas mixture into the environment. It would also be beneficial for a variety of other reasons. It would prevent a fall in concentration of volatile agent in the gas mixture within the circuit, thus reducing the likelihood of awareness post-intubation, and one is more likely to notice a non-filling reservoir bag than a vaporizer that is turned off.1 It may also be more cost-effective, by reducing the amount of gas and volatile agent consumed.

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Permanent anosmia after topical nasal anaesthesia with lidocaine 4%

Editor—A 62-yr-old male patient presented with nasal breathing impairment, cough and facial pain without olfactory discomfort. Fibreoptic flexible endoscopy of the nasal passages was performed, preceded by endonasal topical local anaesthesia (ETLA) with lidocaine 4% spray (two puffs in each nostril), using a plastic dispensing apparatus, with no propellant gas. Inferior turbinate hypertrophy and nasal septal deviation were found. About 10 min later the patient mentioned the onset of anosmia. Olfactory impairment was confirmed by a Sniffin’Sticks™ test battery1 score <16. Head computed tomography (CT) scan was performed to rule out tumour, infection and obstruction. Three months later the patient was still anosmic and the Sniffin’Sticks test battery confirmed previous findings.

Establishing a direct relationship between drug exposure and anosmia is often difficult, and it is frequently hard to determine with certainty the causative role of specific drugs in the development of such a disorder. In this case lidocaine seems the likely cause of the patient’s anosmia, as no other substance either included in the original lidocaine solution or coming from the dispensing apparatus came into contact with the nasal mucosa. Mitochondrial dysfunction with activation of apoptotic pathways2 is the likely mechanism of lidocaine neurotoxicity. Furthermore, ETLA in the supine position and/or in a head-down position can favour contact of the anaesthetic to the olfactory cleft with consequent higher risk of anosmia.3 Smell disorder after ETLA, though usually reversible,4 is a cause of dissatisfaction and fears for the patient and the clinician, with possible legal consequences.5

In conclusion, we suggest performing ETLA with the subject in the sitting position and the head upwards to reduce contact of the anaesthetic with the olfactory cleft. Written informed consent should be obtained from each patient, considering that ETLA will render the procedure more com-
fortable but may cause transient or, as in this unique case, permanent olfactory dysfunction.

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