Finally, they suggested the use of much higher infusion rates of insulin, because it would lead to an increase in the infusion rate of glucose. In contrast to their data (which used variable infusion rates of both insulin and glucose) we actually measured plasma insulin concentrations, which were reported to be in the supra-physiological range of 600–800 pmol litre⁻¹. We are not aware of any scientific evidence suggesting that the infusion rate of insulin described in our paper was too low. On the contrary, it cannot be excluded that their higher and varying insulin infusion rates may have led to a higher and more unpredictable rate of intracellular glucose usage, thus creating the necessity to check plasma glucose more frequently. To answer this interesting suggestion, a dose–response study in cardiac surgical patients is required. Such a study should be designed to investigate the effect of different high concentrations of insulin on the metabolic rate of glucose perioperatively.

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Laryngospasm during subarachnoid block

Editor—We thank Dr Chincholkar for his interest in our case report. To answer the questions raised by Dr Chincholkar, the level of block before the dressing was opened was T11, bilaterally to sharp pain. It may have been higher, but we did not test further as the level was satisfactory for the dressing removal. Only part of the outer layer of the dressing was removed, the patient’s leg was supported at his calf and the wound was not handled at any point. Thus, it is unlikely that removal of the dressing was the cause of laryngospasm. It took at least 3 min for the laryngospasm to break, that is, not immediately after the surgeons stopped removing the dressings. The measures described in our case report namely fluid loading and atropine prevented any further development of a high parasympathetic tone and this in our opinion explains the further uneventful course of the anaesthetic.

We employed sharp pain as a modality of testing as most clinicians would do. We do agree that a simple pin prick test may not equate to the complex mechanisms involved in perception of surgical pain, but this is the most common method of testing the level of block for regional anaesthesia in most clinical settings. Temporal summation is blocked in subarachnoid blocks but not so well in epidural blocks.

We disagree that the onset of bilateral blocks in lateral position is slow. There are multiple factors governing the spread and onset of subarachnoid block. Dr Chincholkar quotes a study of regional anaesthesia for Caesarean section but the complex changes during pregnancy are not comparable to our male patient undergoing foot surgery. Instead, I would draw his attention to a study where the onset of bilateral sensory block to T10 with bupivacaine 0.5% (15 mg) with glucose 8% was a median of 2 min (range 2–10 min). The dose is slightly higher than the bupivacaine 0.5% (12.5 mg) with glucose 8% that we used. In our patient, the block was performed in the right lateral position and the patient was turned supine immediately and hence it is unlikely that the block was unilateral.

We too were perplexed when confronted with laryngospasm during a spinal anaesthetic. What we did was to follow ‘ABC’ as in any emergency. Haemodynamic optimization involved bolus of intravenous fluid, atropine and ephedrine. In our opinion, the laryngospasm responded to the above measures, which were mostly vagolytic.

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S100B in Guillain–Barré syndrome

Editor—Guillain–Barré syndrome (GBS), a subacute inflammatory demyelinating polyneuropathy, is the most common cause of acute neuromuscular paralysis. Up to one-third of patients with GBS require mechanical ventilation (MV)