Correspondence

More about the "Allergic Reaction to Lidocaine"

To the Editor:—In view of the usual high editorial standard in ANESTHESIOLOGY, I could not refrain from reacting to an article in the October issue, "Suspected Allergic Reaction to Lidocaine" by Alistair Lynas.

Fundamentally, this is purported to be the report of a suspected allergic reaction to lidocaine, a subject of particular interest since there has never been a well-documented case of such a reaction. Nowhere does the discussion mention the possibility of reaction to other agents used, particularly procaine, used for the skin wheal and infiltration. I would also be curious about the sterilization of the 3.5 French gauge Bard catheter left in place. These are often used as disposable items nowadays but a number of places still reuse woven silk catheters, sterilizing them by various means. Residual sterilizing agent could also be allergenic. Reaction to Zephiran is a vague possibility but needs mention. It is a shame this agent continues in use because of its rather restrictive antibacterial activity. Finally, the stage for all this might well have been set by the huge dose of Dilaudid used for premedication, together with a good dose of Valium that tends to enhance the action of Dilaudid. Bonica, writing in the 1967 edition of Modell's *Drugs of Choice*, says that a current investigation at the University of Washington finds that 2 mg of dihydromorphinone seem to be the optimum dosage to obtain parallel side effects and equi-analgesia with 10 mg of morphine.

The patient was subjected to an unusual number of attempts to place an intravenous angiocath and to make a caudal puncture, which could well have set the stage for a cardiovascular reaction. The use of a caudal catheter for hemorrhoidectomy seems quite unusual. The skin reaction showed red blotchy "wheals" rather than red "heals," I presume. Next, quite out of keeping with the rest of the article comes an esoteric electrocardiographic term, coronary sinus rhythm. A description of the ECG change or a description such as ectopic atrial rhythm would have been more communicative. Then, although the patient had fully recovered, it was decided to cancel the operation. It would have been of interest to know if anesthesia had developed and why it was thought wise to cancel the operation.

Perhaps I am hypercritical, but it seems to me that our students and young residents need a high standard of scientific reporting toward which they can strive.

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More about Diffusion Anoxia

To the Editor:—The article by Drs. Frumin and Edelist, "Diffusion Anoxia: A Critical Reappraisal" (ANESTHESIOLOGY 31: 243, 1969), seems to me to suffer a surfeit of "Reappraisal" and a relative dearth of "Critical." Their contention is that "clinically significant" evidence of diffusion hypoxia could not be observed using more modern methods of measurement than those employed by Dr. Fink (ANESTHESIOLOGY 16: 511, 1955). My contention is that