lost during transit through the output line. The patient input temperature would then approach ambient temperature.

In this context it is worth emphasizing that the use of disposable blood warming devices at low flow rates is of no benefit in maintaining temperature homeostasis. Measurements of input temperatures in 23 patients receiving blood *via* a disposable blood warming device showed that patient input temperatures were 0–2° C above the operating room temperatures. In all cases the rate of blood transfusion was less than 30 ml · min^{-1}. This suggests a wasteful use of expensive blood warming equipment. Vaghadia[3] has already shown that when the rate of blood transfusion is less than 25 ml · min^{-1} (approximately equivalent to 1 unit of whole blood given over 18 min), there is no advantage in using a disposable warming device. In fact, higher patient input temperatures can be achieved by simply immersing the iv tubing in a warming bath.

Hopefully, anesthesiologists will take into account the anticipated flow rate before resorting to the use of warming devices. If the flow rate is less than 30 ml · min^{-1} and temperature homeostasis is important (*e.g.*, in infants), consideration should be given to insulating the iv lines to minimize heat loss.

HIMAT VAGHADIA,
B.SC. (HON), M.B., B.S., F.F.A.R.C.S.
Resident
Department of Anesthesia
Vancouver General Hospital
University of British Columbia
Vancouver, British Columbia, Canada

REFERENCES

1. Rosen KR, Rosen DA, Broadman L: A simple method for warming intravenous fluid in infants. ANESTHESIOLOGY 64:133–134, 1986
2. Russell WJ: A discussion of the problems of heat exchange blood warming devices. Br J Anaesth 41:345–351, 1969
3. Vaghadia H: Blood warming with the Avon A60 extension set. Anaesthesia 39:932–933, 1984

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Do Not Discontinue Antiarrhythmic Drugs Preoperatively

To the Editor:—Drs. Weiskopf and Stead have recently presented a current and interesting discussion of polymorphous ventricular tachycardia during coronary artery bypass surgery.[1] However, an ambiguity in phrasing appeared in the text that may needlessly delay surgery in some patients with a prolonged QT interval. They state: "In patients on class I antidysrhythmic agents, a prolongation of the QT interval can occur, thereby increasing the susceptibility of the patient to Torsade des pointes. Decreasing the dose of the drug or discontinuing the drug entirely until the QT interval returns to normal is the appropriate treatment." Clearly the two references cited for this statement[2,3] refer to patients who have a history of Torsade, not to all patients receiving drugs that prolong the QT interval as a therapeutic side effect. This recently came to our attention when we encountered a diabetic patient scheduled for elective surgery. He had a history of uncomplicated silent myocardial infarction; subsequent administration of quinidine for frequent premature ventricular beats (PVBs) had resulted in prolongation of the QT interval compared with previous ECGs (from 0.43 to 0.47 s). Surgery was unnecessarily postponed until an appropriate consult could be obtained, with the recommendation that quinidine therapy be continued throughout the perioperative period with no increased risk of Torsade de novo.

LAURENCE LANDOW, M.D.
New England Medical Center
171 Harrison Ave.
Boston, Massachusetts 02111

REFERENCES

1. Weiskopf M, Stead S: Polymorphous ventricular tachycardia during coronary artery bypass surgery. ANESTHESIOLOGY 64:392–394, 1986
2. Smith WM, Gallagher JJ: Les Torsades de Pointes: An unusual ventricular arrhythmia. Ann Intern Med 93:578–581, 1980
3. Soffer J, Dreiful LS, Michelson EL: Polymorphous ventricular tachycardia associated with normal and long QT intervals. Am J Card 49:2021–2028, 1982

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