free epidural morphine sulfate. An epidural infusion of a solution containing 0.125% bupivacaine HCl and 0.002% morphine sulfate was begun at a rate of 10 ml/h.

The next morning, he complained to his nurse of "blurred vision." At this point, he had received a total epidural morphine dose of 5.2 mg. He was free of pain and had full motor function of his lower extremities. Upon further questioning, the patient stated he had "double vision." Examination revealed a vertical nystagmus in both eyes, with the fast component in the downward direction. Because the visual disturbance was troubling the patient, naloxone 100 μg was given intravenously. This diminished but did not completely resolve his symptoms. Ten minutes later an additional 100 μg naloxone was administered intravenously. This resulted in a complete and permanent relief of the nystagmus and his symptoms. The epidural bupivacaine/morphine infusion was continued until the next morning, when the patient was discharged to the ward. His symptoms did not return, nor did he complain of pain while in the recovery room. The only other medication he had received in the recovery room was cefazolin.

Previous to this astute observation by Fish and Rosen,[1] nystagmus had not been identified as a possible side effect of epidural opioids. Hopefully, these reports will stimulate other physicians to be alert for similar problems in patients treated with epidural opioids.

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REFERENCE

1. Fish DJ, Rosen SM: Epidural opioids as a cause of vertical nystagmus (correspondence). ANESTHESIOLOGY 73:785–786, 1990

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Routine Testing for Latex Allergy in Patients with Spina Bifida Is Not Recommended

To the Editor:—Moneret-Vautrin *et al.*,[1] in their discussion of three cases of intraoperative anaphylaxis in children with spina bifida, state that "prick tests and RASTs are reliable for detecting latex allergy." They conclude that such tests should be performed preoperatively on all patients with spina bifida.

Unfortunately, there are no studies to support this statement. We do not yet know the prevalence of clinical rubber allergy in patients with spina bifida; recent surveys[2] suggest that it is between 18 and 28%. Turjanmaa *et al.*[3] have found that the commercially available latex RAST is only 53% sensitive, and no sensitivity or specificity data are available for percutaneous latex testing. We therefore have no data whatever on the predictive value of these tests.

Until prospective studies identify the risk factors and predictors of intraoperative anaphylaxis, physicians must continue to rely on tools that are of demonstrated efficacy. We must obtain accurate histories from our patients, and carefully inquire of patients with spina bifida and their parents whether there have been any unusual, idiopathic, or perioperative allergic reactions in the past. Patients with such a history should be offered preoperative prophylaxis against immediate hypersensitivity reactions and should be spared, whenever possible, unnecessary cutaneous and parenteral exposure to natural rubber products.

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REFERENCES

1. Moneret-Vautrin DA, Laxenaire MC, Bavoux F: Allergic shock to latex and ethylene oxide during surgery for spina bifida. ANESTHESIOLOGY 73:556–558, 1990
2. Meerpol E, Kelleher R, Bell S, Leger R: Allergic reactions to rubber in patients with myelodysplasia (letter). N Engl J Med 323:1072, 1990
3. Turjanmaa K, Reunala T, Rasanen L: Comparison of diagnostic methods in latex surgical glove contact urticaria. Contact Dermatitis 19:241–247, 1988

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In Reply:—Slater and Mostello rightly question the specificity and the sensitivity of these prick-tests because until now no data have been available. We have studied 907 physicians, surgeons, nurses, and hospital employees using both a questionnaire and prick test to a latex emulsion.[1] In 18 cases, allergy to latex was suspected on the basis of clinical symptoms. Prick tests in all 18 were positive (sensitivity 100%). In 889 subjects with a negative clinical history, 883 prick tests were negative (specificity approximately 99%). In 3 of the 6 subjects with a

negative history and positive prick-test, a use test was performed and positive in one case showing that, at least in this case, the prick test was not a false positive.[1] These results were obtained with the use of a colloidal suspension or prevulcanized rubber particles. Sensitivity may not be as good with prick tests through latex gloves, and the residual allergenicity of latex may even depend on different brands of gloves.[2] The high sensitivity of prick tests to latex is based on the nature of allergens, which are natural proteins, as is the case for inhalants or food allergens.

Using prick tests to latex, we have started prospectively testing children with spina bifida. In the first eight children tested without any history of allergy to latex, prick tests were positive in four and confirmed by positive RAST, ranging from 0.36 to 2.45 PRU/ml. In other words, the possibility of predicting latent sensitization to latex seems good with prick tests. We agree with Dr. Slater and Dr. Mostello that the risk of intraoperative anaphylaxis cannot be precisely defined even when latent sensitization has been detected. But approximating this risk may be important in light of similar studies examining the risk of anaphylaxis during chemonucleolysis with chymopapain: in patients with positive prick tests to chymopapain, five of six experienced anaphylaxis (*versus* 3 of 282 patients with negative tests).[3]

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REFERENCES

1. Beaudouin E, Pupil P, Jacson F, Laxenaire MC, Moneret-Vautrin DA: Allergie professionnelle au latex: Enquete prospective sur 907 sujets du milieu hospitalier. Rev Fr Allergol 30:157–161, 1990
2. Turjanmaa K, Laurila K, Makinen-Kiljunen S, Reunala T: Rubber contact urticaria: Allergenic properties of 19 brands of latex gloves. Contact Dermatitis 19:362–367, 1988
3. McCullogh JA, Canham W, Dolovich J: Skin testing for chymopapain allergy: A preliminary report. Ann Allergy 55:609–611, 1985

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Getting the Bugs Out

To the Editor:—The preoperative anesthesia visit has been shown to be as important as some premedication in allaying anxiety.[1,2] However, it is not uncommon to overhear entomologic references such as, "Here's a little bee sting" (little?) or "Here comes a Texas mosquito bite" (Texas?) preceding local anesthetic infiltration. Such comments may reverse the rapport you have tried to establish. Why bring bugs into our work place?

Fear of insects is widespread. Who can forget the many horror movies starring giant bugs or swarming insects? Warnings abound of killer bees migrating to the United States. Approximately 1 in 100 persons is sensitized to *Hymenoptera* (bees, wasps, and hornets) venom,[3] and the other 99 all know you can die from a bee sting. There are at least 40 deaths per year in the United States from *Hymenoptera* stings and serious nonfatal reactions in 1–10 persons per 100,000 per yr.[4,5] In one study,[6] 4,992 Boy Scouts were surveyed for previous stings; an incidence of systemic reactions of 0.4% was found.

Mosquitoes raise thoughts of uncleanliness and malaria and equine encephalitis and have been investigated (though rejected) as a vector for HIV transmission.[7,8] Besides, do mosquito bites sting and burn like local anesthesia can? That may confuse your patient and decrease trust.

Let us simply state, "I am going to numb this area with some local anesthesia now. It may hurt for a moment." For small areas, such as for intravenous placement, multiple-dose solutions such as saline may be used and do not cause pain on injection.

The anxiety associated with insect bites may be greater than the benefit of such analogies.

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REFERENCES

1. Egbert LD, Battit GE, Turndorf H, Beecher HK. The value of the preoperative visit by an anesthetist. JAMA 185:553–555, 1963
2. Leigh JM, Walker J, Janaganathan P. Effect of preoperative anaesthetic visit on anxiety. Br Med J 2:987–998, 1977
3. Fath JJ, Cerra FB. The Therapy of Anaphylactic Shock. Drug Intell Clin Pharm 18:14–21, 1984
4. Reisman RE. Insect allergy, Allergy Principles and Practice. Volume 2. 3rd edition. Edited by Middleton E, Jr., Reed CE, Ellis EF, Adkinson NF, Jr., Yunginger JW. St Louis, The CV Mosby Co., 1988, p 1345
5. Barnard JH. Studies of 400 Hymenoptera sting deaths in the United States. J Allergy Clin Immunol 52:259–264, 1973
6. Settipane GA, Boyd GK. Prevalence of bee sting allergy in 4992 Boy Scouts. Acta Allergol 25:286–291, 1970
7. Webb PA, Happ CM, Maupin GO, Johnson BJB, Ou C, Monath TP. Potential for insect transmission of HIV: Experimental exposure of *Cimex hemipterus* and *Toxorhynchites amboinensis* to human immunodeficiency virus. J Infect Dis 160:970–977, 1989
8. Zuckerman AJ. AIDS and insects (letter). Br Med J 292:1094–1095, 1986

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