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A Second Sir Humphry Davy?

To the Editor:—I almost fell off my chair when I read the letter apparently by Sherry and Davy.¹ Sir Humphry Davy—father of the miners' safety lamp—returned to life after dying in 1829? Or is it a misprint, and the Department of Anaesthesia is named after the great man?

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In Reply:—Dr. Hool is correct. The apparent rebirth of Sir Humphry Davy can be attributed solely to an editorial misprint. Although our action several years ago to eliminate the galley proof stage of the Correspondence section has increased its timeliness, at the same time it does expose the Journal to an occasional embarrassing moment such as the apparent return to life of an individual thought dead for over

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Sudden Asystole after Spinal Anesthesia Treated with the "Pacing Thump"

To the Editor:—We wish to confirm the efficacy of the precordial "pacing thump" as reported by Chester¹ during the treatment of sudden asystole after spinal anesthesia.

A 60-yr-old man scheduled for right inguinal herniorrhaphy was taken to the operating room; an intravenous infusion of normal saline was begun; and he was positioned in the right lateral decubitus. Fentanyl 50 µg and midazolam 1.5 mg were administered intravenously. Spinal anesthesia was initiated at the L3–L4 level using 15 mg hyperbaric 0.75% bupivacaine in dextrose with 0.2 mg added epinephrine. After 7 min the anesthetic level was T4 on the right side, and the patient was turned supine. Immediately after being placed supine, the patient had a T1 sensory level on the right side and a level below T12 on the left. Approximately 3 min later the patient had a C8 sensory level on the right and a T2 sensory level on the left. The patient was very alert. Because of the presumed cardiac sympathetic blockade, it was decided to prophylactically administer atropine to counteract unopposed vagal tone. The heart rate was 58 beats per min and 850 ml 0.9% saline had been infused at this time.

However, before atropine could be administered, the heart rate suddenly decreased to 40–50 and almost instantly to 20–30 beats per min and lower. At a point when there were only two QRS complexes seen across the screen of the ECG monitor (approximately 6–8 s between beats), pacing thumps were begun precordially while atropine 1.2 mg and epinephrine 50 µg were administered intravenously. When the pacing thumps were first started the patient asked, "Why are you beating on my chest?", but then he suddenly became unconscious, and no spontaneous QRS complexes could be seen across the screen. Positive pressure ventilation with oxygen was begun by mask. The pacing thumps were effective in capturing and creating a QRS complex approximately every second or third thump. This allowed the atropine and epinephrine to circulate. The patient's heart rate and rhythm were

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1. Sherry E, Davy Sir H: Hazards of reusing disposable syringes: II. ANESTHESIOLOGY 74:790, 1991

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150 years. We are taking corrective action in an attempt to prevent further recurrence of such unintended reappearances.

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quickly restored to a sinus tachycardia with prompt return of consciousness. At this point the sensory anesthetic level was noted to be C8 on the right and T1 on the left. The patient had strong hand grips bilaterally. He was able to breathe well. Oxygen was administered via nasal cannula. Ephedrine 50 mg was administered intramuscularly to maintain sympathetic tone. The surgical preparation was begun, and the operation proceeded uneventfully.

We report this case to emphasize again that sudden asystole can occur during spinal anesthesia² and that the pacing thump is effective in providing some circulation in this situation, allowing cardiac medications to circulate and promptly have the desired effect.

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