Anesthesiology
2000; 92:1201

In Reply:—We appreciate the interest of Dr. Abouliesh *et al.*[1] in our recent case report. We agree that it is not possible to differentiate viral meningitis from aseptic meningitis based on the cerebrospinal fluid findings and do not think that this differentiation is implied in our discussion of the case. More importantly, the suspected diagnosis of aseptic meningitis was subsequently further supported by the inability to isolate a virus from cultures of cerebrospinal fluid or from rectal and nasopharyngeal swabs. Although viral isolation may not always be possible, and the isolation of a virus is not conclusive evidence that the virus is the causative agent of meningitis, we think that this evidence strongly supports our conclusion of aseptic meningitis. Additionally, we were careful to state in the final paragraph that we could not prove a causal relation between the aseptic meningitis and the performance of the spinal anesthesia.

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Aerosolization of Lidocaine

To the Editor:—The apparatus described by Dr. Balatbat *et al.*[1] for applying lidocaine to the airway bears an uncanny resemblance to an arrangement that I first described in 1998.[2] I do appreciate, however, that it is not always easy to identify instances of previous publication, even with the most assiduous of literature searches, particularly if the publication in question happens to be correspondence. I say this with confidence because I made the same error myself; the arrangement was originally described by Dr. Tran in 1992.[3] Although others have judged my apparatus to be "more simple and ingenious" than that described by Dr Tran,[4] I suspect the same cannot be said for the arrangement described by Dr. Balatbat.

Whatever the merits of the various descriptions, it is worth emphasizing that the Tran-Mackenzie-Balatbat spray is a simple, elegant, and effective method for the topical application of drug sprays to mucosa-lined cavities, and is frequently adopted by those who have seen it in action, including otorhinolaryngologists.

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2000; 92:1202

In Reply:—We thank Dr. Mackenzie for his comments. The reason we submitted this article for publication was to share our experiences with this simple and effective means of aerosolizing lidocaine for topical airway anesthesia. Despite an extensive search of the literature, we were not able to find a technique similar to that described in our report, and it would be such a loss to keep this method to ourselves because "it really works!" We appreciate very much that Dr. Mackenzie called to our attention the similar device he and Dr. D. Tran had developed previously.

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Acetaminophen Dosage in Pediatric Practice

To the Editor:—The article by Korpela *et al.*[1] regarding the morphine-sparing effects of different doses of acetaminophen concerns us in several ways. Although the study design takes into account a "placebo" group, we think that this group is unnecessary and its use provokes significant ethical questions. It is unlikely that any anesthetic technique for this sort of surgery would be planned to involve no analgesia at all, as in the untreated group. Although the placebo effect is undoubtedly of some value, this group did not even have analgesia in the intraoperative and immediate postoperative periods until rescue anesthesia was given.

Two groups (groups I and II) received inadequate analgesia intraoperatively and in the immediate postoperative period. These groups also had consequent side effects from rescue intravenous morphine that was necessary. Surely, one of the aims of day-care anesthesia is to minimize side effects.

Second, the recent vogue of using ever increasing doses of acetaminophen—in this article 60 mg/kg acetaminophen is recommended—brings into question the principal of using simple and normally safe pediatric drugs in a way that could lead to difficult problems. The study design ensured that study patients received no further acetaminophen; however, acetaminophen is probably the most common drug used in the home. There are recent case reports of severe, reversible hepatic toxicity when acetaminophen is used in therapeutic amounts.[2] To use a single high dose of the drug simply to provide an adequate therapeutic level more quickly merely indicates the inadequacy of the single-drug technique, and reinforces what we already know: Treating postoperative pain using perioperative analgesia, including local anesthesia, and simple analgesics (*e.g.*, acetaminophen, nonsteroidal anti-inflammatory drugs) is far more beneficial. Encouraging ever increasing doses of this safe drug potentially could lead to serious morbidity. Surely it is better to use a "balanced" anesthetic technique.

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