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Severe anaphylaxis during general anaesthesia in a β -blocked cardiac patient: considerations

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Sir,

A 55-year-old female with coronary artery disease, hypertension and diabetes mellitus, medicated with ramipril, metoprolol and insulin underwent elective laparoscopic cholecystectomy. Induction of general anaesthesia with propofol, fentanyl and vecuronium was uneventful. Intraoperatively 5 mg of i.v. metoprolol was titrated to blunt hypertension. Towards the end of surgery, diclofenac sodium, 75 mg, was added to the i.v. infusion. Within 5 min the blood pressure dropped to 40/22 mmHg and florid red wheals on arms, chest and thighs was recognized.

There was no response to mephentermine (mixed α - and β -agonist) 18 mg i.v., and an anaphylactic reaction was suspected. Infusion of diclofenac was stopped, followed by a rapid infusion of i.v. fluid and 100% oxygen. Further, adrenaline, 0.1 mg, and hydrocortisone, 300 mg, was administered i.v. Gradually, the arterial pressure restored to normal levels. The patient also developed mild bronchospasm, which responded to ipratropium and salbutamol nebulization. Recovery was uneventful.

Anaphylaxis to non-steroidal anti-inflammatory drugs under anaesthesia is rarely reported, and when reviewing the history, we found that this patient had a previous suspected allergic reaction to diclofenac that was not communicated to the anaesthesiologist.

Another remark is that patients with pre-existing cardiovascular disease and those on β -blockers are reported to have increased incidence and severity of anaphylaxis (1, 2). β -blockers increase the release of mediators via modulation of adenylyl cyclase, and decrease the cardiovascular compensatory changes to the anaphylactic shock. Adrenaline may be ineffective or promote undesired α -adrenergic and reflex vagotonic effects in β -blocked patients (3). Glucagon, isoproterenol infusion and inhaled ipratropium are recommended in refractory anaphylactic shock for these patients (3). Some authors advocate that risk reduction measures should be considered in β -blocked patients susceptible to anaphylaxis (2).

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Detection of inadvertent tracheal placement of nasogastric tubes

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Sir,

I read with interest the article by Fuchs et al. (1) regarding the use of endotracheal cuff pressure measurement to detect tracheally misplaced nasogastric tubes. It seems that the actual