

the rapid infusion of fluids in the form of crystalloids or colloids to fill the vascular compartment.^[2] The authors have not mentioned anything about the fluid resuscitation.

Third, it is recommended to start an intravenous infusion of adrenaline rather than dopamine after the initial doses.^[2] It is not clear why the authors chose to use dopamine in place of adrenaline.

Fourth, the oxygen saturation dropped to 89%; however, the chest auscultation findings are missing in this report. These are important to rule out bronchospasm. Similarly there is no mention of the compliance of the lungs and the airway pressures. The other cause of desaturation in this patient could be decreased pulmonary blood flow due to hypotension itself.

Fifth, the patient had a body mass index (BMI) of 36. The recommended dose of hydrocortisone is 1–2 mg/kg. This obese patient received only 100 mg. Also, the literature supports the use of either hydrocortisone or methylprednisolone and not dexamethasone which was given in this case.^[3]

Sixth, the patient was hypertensive; therefore, it would be interesting to know the medical treatment. This has direct implications on the outcome because many times they are receiving beta-blockers which may decrease the effectiveness of adrenaline.

Seventh, the patient had a BMI of 36 and she was hypertensive. Fentanyl at 1 µg/kg and propofol at 1 mg/kg is a highly insufficient dose for this hypertensive patient. Further, whether an inhalational agent was also used is doubtful from the presentation.

Eighth, the authors decided to get the surgery done after this episode with the patient still on inotropic support. How safe is this? One must remember that anaphylaxis can recur. What muscle relaxant would one give if the patient comes out of the effect of muscle relaxant in this clinical setting? We must remember that cross-sensitivity is common between muscle relaxants.^[3] The other option could be propofol infusion or deep inhalation anaesthesia. However, it is unwise to use this technique in this patient who was already on dopamine infusion. Therefore, I feel that for this elective surgery, the safest approach would have been stabilisation and postponing the case till the event is adequately investigated.

Anaphylaxis to vecuronium: Revisited

Sir,

I read the letter to the editor by Dr. Chowdhry *et al.* with interest.^[1] First of all, I would like to congratulate the authors for their successful management of a life-threatening anaphylaxis. However, some aspects of the scenario need reconsideration.

First, the bolus dose of adrenaline used for the management was too large. Most of the recommendations advice a bolus dose of 100–200 µg intravenous for this clinical presentation where the heart rate was 52/min and blood pressure was 74/32 mm Hg.^[2]

Second, one of the hallmarks of anaphylaxis is profound vasodilatation leading to sequestration of blood from intravascular to interstitial space. This necessitates

Lastly, we often forget but it is a must to give some medialert-band or similar type of thing so that the patient is not given the same drug again for some other surgery in future.^[3]

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Access this article online	
Quick response code	Website: www.ijaweb.org
	DOI: 10.4103/0019-5049.104590