CORRESPONDENCE

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In Reply.—Doctor Moore can be commended in this attempt to further educate personnel regarding the continuing dangers of lidocaine concentrates “for dilution only.” The purpose of my initial correspondence was to emphasize this danger, to increase reporting of any such occurrences, and, hopefully, to induce removal of the 20% preparations from the market. The morbidity and, especially, mortality of inadvertent injection of concentrated solutions can be prevented by use of the now available safer alternative formulations. The use of 4% solutions in bottles to constitute lidocaine infusions (should self-constitution be required) was proposed because of the inherent margin of safety: use as if it were the 2% solution results in dosing only two, instead of ten, times the intended dose, and would probably be better tolerated by the patient. Drawing up a solution into a syringe also provides extra interaction time in which to prevent a mistake, and this preparation has been found to have a good track record of safety via FDA reports.*

Very recently, International Medication Systems LTD, So. El Monte, CA, has begun to market 1 gm lidocaine sterile powder for constitution in a formulation similar to the familiar Anectine Flo-Pac® under the trade name Bag-A-Mix®. Lidocaine powder would be extremely difficult to inject, and can now be highly recommended, should the need to constitute a lidocaine infusion persist. The “protective-needle-housing” on ready-to-use syringes in no way precludes direct IV injection. Alternatively, if these ready-to-use syringes were not armed with needles, but with ¼ inch diameter spikes similar to those on common infusion administr-

* Graham CF: Report to the anesthesia and life support advisory committee. Food and Drug Administration, Rockville, Maryland, October 24, 1984

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Life-threatening ECG Artifact during Extracorporeal Shock Wave Lithotripsy

To the Editor.—Intraoperative dysrhythmias during extracorporeal shock wave lithotripsy (ESWL) have been recently reported.1 We describe a case during which ECG anomalies with potentially serious consequences were observed.

A 68-yr-old woman with nephrolithiasis and controlled hypertension was admitted for ESWL. Prior general anesthetics had been uneventful. She denied angina pectoris, palpitations, or known cardiac abnormalities. Electrolytes and 12-lead ECG were within normal limits.

Pre-induction blood pressure was 130/75 and heart rate was 70. Intravenous induction with thiopental, 450 mg, and fentanyl, 50 μg, was followed by succinyldicho-

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