The editor of The Source AAMS1 network, subscribers to The Source may gain access to the AAMS1 Special Services Network.

On the CompuServe Information Service,1,2 AAMS1 provides two separate communication facilities: 1) The AAMS1 Communications Network (another on-line version of the AAMS1 News), and 2) The AAMS1 Medical Forum, also known as the MEDical Special Interest Group (MEDSIG). The MEDSIG provides an organized framework for communication with other physicians by means of electronic mail, a computer bulletin board, and online conferences. It is also possible to exchange text files or programs by means of the SIG/ACCESS database system. The AAMS1 databases on CompuServe are freely accessible by all subscribers to the CompuServe Information Service.

CompuServe and The Source are accessible through standard telephone lines, requiring only a computer terminal and a 300 or 1200 baud modem. Many physicians, however, choose to use their personal computers to send (upload) and receive (download) messages and programs directly from disk files in order to save time and communications costs. Subscribers to these National Information Utilities are charged only for the time they are connected to the service, and billing is customarily through a bank card. These databases of software and medical information have been created by donations from AAMS1 and MEDSIG members. One advantage of this method of software distribution is that program authors do not have to make and distribute copies. In addition, software updates can be entered in the database with notices distributed to all anesthesiologist members.

Michael Ashman (CompuServe ID: 76010,543 or 70315,224) and Franklin Scamman (CompuServe ID: 71515,452) are section coordinators for the Anesthesiology PSG. Messages may be addressed to them using the “Leave message” command of CompuServe’s MEDSIG or by means of CompuServe’s electronic mail system, “EMAIL.” Dr. Ashman has created an extensive series of files, MEDSIG.HL1, MEDSIG.HL2, MEDSIG.HL3, and MEDSIG.HL4, which are available through the MEDSIG’s SIG/ACCESS database system and describe in great detail how to find your way around CompuServe and the MEDSIG and how to upload and download files.

We strongly encourage computer-minded anesthesiologists to join AAMS1, subscribe to The Source or CompuServe, and participate in program and information file exchange for the mutual benefit of all anesthesiologists. Information about membership in AAMS1 is available by calling 301-657-4142. Information about CompuServe is available by calling 800-848-8990 (in Ohio, 614-457-0802). Information about The Source is available by calling 800-336-3366 (in Virginia, 703-734-7500).

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Another Case of Grand Mal Seizure after Fentanyl Administration

To the Editor.—We read with great interest the report of a grand mal seizure after the administration of fentanyl by Safwat and Daniel.1 The report was read the day after we encountered a similar situation in our hospital. Our patient was a 17-year-old male who had been anesthetized on two prior occasions, both of which, were uneventful. He returned for an open reduction of an ankle fracture. After placement of the patient on the OR table, with both arms secured to arm boards, the administration of 100 µg of fentanyl resulted in a grand mal seizure so severe the patient dislocated both shoulders, and he required closed reduction under general anesthesia. The seizure was controlled with 300 mg of thiopental. The patient had an uneventful recovery. The patient’s post-

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operative course was also uneventful. A neurologic consult, which included a negative EEG, was obtained prior to discharge. A review of the past two anesthetic records revealed the only new drug used in the anesthesia was fentanyl.

Seizure activity after narcotic administration as reported by Carlsson\(^a\) indicated that no such activity had been reported following fentanyl administration; however, based upon the report from Safwat and Daniel,\(^b\) and personal experience, I would like to join in the alert to colleagues regarding possible seizures with low-dose fentanyl administration.

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An Aid to Airway Maintenance during Operative Sedation

To the Editor—Upper airway obstruction may result during neuroleptanalgesia (NLA) and other sedative an-
esthetist techniques due to relaxation of the muscles of the upper airway.\(^1\) This can be particularly troublesome in ophthalmologic cases, where patients may be elderly and edentulous. One accepted treatment, jaw positioning,\(^2\) is difficult because the anesthesiologist is remote from the head of the patient.

Another accepted treatment, airway insertion,\(^3\) is usually unsuccessful because airways are poorly tolerated in lightly sedated patients. I have found a simple and effective way to elevate the jaw with a cervical collar.

When the patient enters the Operating Room, a semi-rigid padded cervical collar (A&A Orthopedic Appliances #605LS, Miami, Florida) is placed around the patient’s neck, the collar is turned upside down so that the notched end lies adjacent to the sternum (see fig 1). The collar snugly and comfortably supports the jaw at the midline while leaving adequate space at the sides of the neck.

I have used this collar for over 50 cases and it has been well-accepted by patients.

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