CORRESPONDENCE
Anesthesiology
77:1232, 1992

Propofol and Awareness: I

To the Editor— I have read with interest the recent article by Kelly and Roy.1 Of particular interest were the statements that "[the] patient's hypertension and tachycardia associated with laryngeal suspension could have suggested inadequate anesthetic depth. Autonomic signs, however, are unreliable indicators of awareness secondary to light anesthesia. We chose to treat this episode with labetalol rather than more propofol..." (Italics added.) Perhaps we should conclude from this case report only that labetalol provides little or no amnesia when used as an adjunct to light anesthesia.

MARK D. TASCH, M.D.
Clinical Associate Professor
Department of Anesthesia

Indiana University School of Medicine
1120 South Drive
Feder Hall #204
Indianapolis, Indiana 46202-5115

REFERENCE
(Accepted for publication August 24, 1992)

Anesthesiology
77:1232, 1992

Propofol and Awareness: II

To the Editor—Kelly and Roy1 report awareness under propofol anesthesia when used as a sole anesthetic for laser surgery to the vocal cords. They tailored the anesthetic technique to ensure a rapid recovery. Propofol has many desirable properties (e.g., rapid elimination, low potential for emesis, versatility) and would seem to be a good choice in this context. I would question, however, the treatment of hypertension and tachycardia with labetalol, rather than deepening the anesthetic. The authors state that autonomic signs are unreliable indicators of awareness secondary to light anesthesia. This would seem to me to be an over-generalization. Surely when a deliberately light anesthetic is being given, particularly with a single agent, we should respond to significant signs of sympathetic activity by increasing the depth of anesthesia. This can be achieved using several different agents, without prolonging recovery time unduly. Merely blocking the autonomic manifestations of awareness or inadequate anesthesia with a β-blocker is not a logical reaction in my view. I am pleased that the authors have modified their technique in view of this experience.

ROBIN G. COX, M.B., B.S., F.F.A.R.C.S.
(ENG.), F.R.C.P. (C.)
Clinical Assistant Professor
Departments of Anaesthesia and Paediatrics
University of Calgary
Alberta Children's Hospital and Child Health Centre
1820 Richmond Road SW
Calgary, Alberta, Canada T2T 5C7

REFERENCE
(Accepted for publication August 24, 1992)

Anesthesiology
77:1232-1233, 1992

Propofol and Awareness: III

To the Editor—In a recent case report,1 the authors state the reasons why propofol is a suitable drug for use during microsurgical surgery and then describe a method that cannot be considered as normal practice. First, the authors use an induction dose to lower the end of the range recommended in the package insert. Second, they use an infusion at the rate recommended as an adjunct to nitrous oxide 60-70%, although they use no nitrous oxide. Third, they treat surgically induced hypertension and tachycardia with labetalol as a first-line drug.

I use propofol with air and oxygen for a wide variety of procedures but particularly microsurgical and bronchoscopic surgery. It gives

1232