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Oral Ketamine for the Management of Combative Autistic Adult

To the Editor:—Anesthetic management of uncooperative patients often is difficult, particularly when they are violent or incapable of understanding instruction. These patients may be impaired because of mental or neurologic disease. One such situation is autism. Although use of oral Ketamine as a premedication is well described in children, its use in the management of violent or uncooperative adults is not. I report these two cases because of the unique situation these autistic patients presented for an anesthetic.

First Case Summary

A 19-year-old, 118-kg man with a lifelong history of autism came to the outpatient surgery department for removal of an infected toenail. The patient had a history of self-abusive and violent behavior. He was taking fluoxetine and chlorpromazine nightly. The morning of surgery, he was administered 100 mg chlorpromazine orally at home. At arrival he was agitated and pacing. He began banging his head into walls and yelling. His mother was present with an electrical “stun” gun, should his behavior become uncontrollable. She had used this device in the past to protect herself from him at home. Because of his size, strength, and violent behavior, the planned procedure was cancelled and rescheduled.

One month later, the patient returned for the elective surgery. He was administered 5 mg haloperidol 600 mg ketamine in a small amount of Coca Cola. The patient became sedate during the next 20 min. He was taken to the operating room. The patient was induced with halothane and nitrous oxide. An intravenous line was placed for antibiotics and nightly medications. Local anesthesia was administered by the surgeon before removal of the toenail. After an uneventful anesthetic and surgical procedure, the patient was taken to the recovery room. He slowly returned to an alert but sedate condition. Throughout his 2-hour recovery period, he remained cooperative and quiet. He was discharged to the care of his parents. He was reportedly back to baseline condition within 6 hours of discharge and had no discernible adverse consequences of the experience.

Second Case Summary

A 35-year-old, 60-kg male came to the outpatient surgery department for dental reconstruction and cleaning. His only medication was carbamazepin, prescribed for a history of seizures. Before arrival, he was administered 0.25 mg triazolam by his caregiver. He initially cooperated with the nurse obtaining vital signs at admission, but soon became agitated and attempted to leave. A second dosage of triazolam had no effect. He was then administered 600 mg ketamine in Coca Cola. Within 20 min, the patient was sedate and cooperative. The patient was transported to the operating room and received a general anesthetic lasting 3 hours. Recovery was uneventful and he was discharged to the care of his guardian. No complications were noted by his caregivers after discharge.

Summary

Autistic patients with symptoms necessitating operative procedures can be challenging. They frequently cannot communicate their needs or desires. Cooperating in unfamiliar environments with unfamiliar individuals can accentuate the difficulties for the patient. The two cases presented herein represent the difficulties of achieving adequate premedication to allow the patient to be safely anesthetized.

The administration of ketamine orally as a premedication for operative procedures has been reported frequently for children. The use of oral ketamine as an analgesic also has been described in adults for postamputation stump pain, postherpetic neuralgia, phantom limb pain, neuropathic pain, and cancer pain. The use of ketamine as a sedative in adult patients has not been described.

Sedating uncooperative patients in a nonforceful manner is difficult. Attempts to either physically restrain or administer intramuscular injection in uncooperative or violent adults can be dangerous. The use of oral benzodiazepines, barbiturates, and butyrophenones is not always successful in achieving sedation and cooperation of the patient. The administration of ketamine in a drink to mask the drug may be an acceptable alternative in some autistic or uncooperative adult patients.

Kenneth L. Bachenberg, M.D.
Bellingham, Washington

References

2. Baldinell L: An autism patient treated with different anesthesia
and sedation techniques over 13 years. G Anest Stomatol 1991; 20:20–2

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PEDIATRIC-NASOTRACHEAL INTUBATION MADE ATRAUMATIC

To the Editor — Bleeding is a troublesome complication of nasotracheal intubation that can both promote laryngospasm and impair subsequent attempts at laryngoscopy. Even when preventive measures are used (oxymetazoline nasal drops, tube lubrication, smaller tubes) bleeding complications can occur. In a prospective study, a “globule” of tissue was present on the tube tip in 33 of 100 patients after nasotracheal intubation.1 More dramatic reports such as avulsion of the turbinate2 or retropharyngeal dissection3 have been described.

Local practice at our hospital is a simple modification of the technique for nasotracheal intubation that may decrease the incidence of bleeding. An entire red rubber catheter (size 10–12 French for pediatric patients) is fitted over the end of the nasotracheal tube before its advancement, by placing the end of the endotracheal tube into the flared end of the catheter. This presents a smooth noncutting surface to the nasal mucosa as the tube–catheter combination is advanced. Using direct laryngoscopy and a McGill’s forceps, the catheter is removed in the oropharynx before final advancement of the nasotracheal tube. This technique is simpler to perform than a previously suggested technique in which orotracheal intubation precedes the nasotracheal catheter–tube combination.4 This technique is also simpler and cheaper than serial dilations with nasal trumpets5 and avoids the risk of losing a small foreign body in the airway when a finger glove is used to cover the tube tip.6

Tom Elwood
Acting Assistant Professor

References

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Sally Parker
Acting Assistant Professor
Chandra Ramamoorthy
Associate Professor
Department of Anesthesia and Critical Care Medicine
Seattle, Washington

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