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Preservative in fentanyl preparations

To the Editor:
We read with interest the Letter to the Editor by Fukuda and Dohi concerning possible anaphylactic reactions to fentanyl[1] (Fentanyl-Janssen, Sublimaze).

For the sake of clarity, we wish to point out that only fentanyl *vials* contain preservatives, the *ampoules* do not. In most countries, only the ampoules are available. The vials contain methylparasept 0.5 $mg \cdot ml^{-1}$ and propylparasept 0.05 $mg \cdot ml^{-1}$.

Another usage area in which this difference could be important is epidural and/or intrathecal analgesia, for which it is advised that only the ampoule-packed fentanyl should be used.

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Use of fiberoptic bronchoscope to assist placement of a Fogarty catheter as a bronchial blocker

To the Editor:
Although most would agree that tracheal intubation with a double lumen tube is the preferred method for single lung ventilation during thoracic anaesthesia,[1] technical problems occasionally make this procedure difficult. Alternative methods include the passage of an endobronchial blocker such as a Fogarty catheter (American Edwards Laboratories), alongside a single lumen endotracheal tube, through the larynx and trachea, and past the tip of the tube into one of the mainstem bronchi.[2] This latter technique may also be impractical if airway anatomy makes standard laryngoscopy impossible.

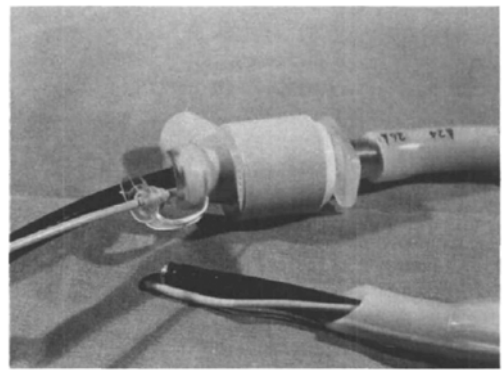

FIGURE 1 Introduction of Fogarty catheter.

Our patient, a 62-year-old male, presented for mediastinoscopy after routine chest films revealed a lesion in the right upper lobe. After induction of anaesthesia with thiopentone and succinylcholine, the patient was manually ventilated with bag and mask but several attempts at orotracheal intubation were unsuccessful. Spontaneous ventilation was allowed to resume and a blind nasal intubation was performed with difficulty. The mediastinoscopy revealed no evidence of inoperability. In retrospect, the inability to intubate orally was likely secondary to poor neck mobility, limited mouth opening, and a prominent maxilla.

The patient was scheduled for right pneumonectomy. Premedication was with intramuscular morphine and glycopyrrolate and followed by intravenous fentanyl and droperidol. Nebulized four per cent lidocaine provided pharyngeal, laryngeal, tracheal and carinal anaesthesia. Oral fiberoptic intubation with 9.0 mm cuffed endotracheal tube was performed easily. With the bronchoscope *in situ*, a 6.0 Fogarty catheter, with the stylet in place, was passed through the clear cap of a fiberoptic bronchoscope adaptor (Portex; Markham, Ontario) (Figure 1), down the lumen of the endotracheal tube, and guided into the right mainstem bronchus. The bronchoscope and Fogarty stylet were removed, and the cap sealed.

Inflation of the Fogarty balloon, manual ventilation, and auscultation of the right chest confirmed the blocker's efficacy. Anaesthesia was then induced and the surgical procedure commenced (Figure 2).

After the right chest was open, the Fogarty balloon was

FIGURE 2 Fogarty catheter in place.

again inflated. Ventilation of the right lung ceased and pneumonectomy was easily performed. The patient was extubated postoperatively and made an uneventful recovery.

Several points are emphasized:

1 Use of the adaptor allowed passage of the Fogarty catheter through the endotracheal tube. After removal of the bronchoscope, an adequate seal was maintained by closing the cap.
2 Tape was used to secure the Fogarty catheter to the endotracheal tube adaptor to prevent movement within the tracheo-bronchial tree. The bronchoscope should always be available so that suspected displacement of the blocker may be readily investigated.
3 Use of a single lumen tube in the "difficult" intubation may be preferable if postoperative mechanical ventilation is anticipated.
4 Careful preoperative examination will minimize the number of airway "surprises" which are notorious for adding grey hair to the heads of anaesthetists.

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Treatment of persistent penile erections during urological procedures

To the Editor:

A serious although infrequent inconvenience to urologists is the persistent penile erection of a male patient, that renders impossible some procedures, such as cystoscopy. Many standard anaesthesia[1–5] and urology[6–11] texts are unhelpful, although Bodner[12] offers the following suggestions; ice-packs, ganglion blockade and muscle relaxants (tubocurarine), added barbiturate or depth of general anaesthesia, methocarbamol, and metaxalone, noting that none are reliable and that all may be inconvenient or hazardous. References to the problem are sparse, Benzon *et al.*[13] review the use of ketamine (noting failures) and mention the use of methoxamine and phenylephrine. I have heard a host of other suggestions: alpha, beta, ganglion and muscarinic blockade (or agonism!), administration of methantheline bromide, narcotics, benzodiazepins, butyrophenones or phenothiazines in conjunction with and as premedication for anaesthesia, the use of sub-arachnoid or extra-dural regional block and substitution between inhalational anaesthetics. All of these manoeuvres are either time-consuming, unreliable, or have undesirable additional effects and in desperation, a surgeon may even resort to perineal urethrotomy.[13] There is a simple alternative, used I am sure by others, but unpublished as far as I am aware, that may be worthy of wider recognition.

Blockade of the dorsal nerves[14] of the offending organ, with any handy vasoconstrictor-free local anaesthetic (e.g., one per cent lidocaine), is quick and easy to perform and on five occasions I have found it to be rapidly efficacious. A modest flaccid engorgement still remained after a few minutes, but was not bothersome. Four of these patients were under otherwise satisfactory inhalational general anaesthesia while one was paraplegic and awake.

The physiology of penile erection has been reviewed by Comarr[15] and by Weiss.[16] It is a complex interaction of sympathetic, parasympathetic and supratentorial efferents via several paths which is responsible for the initiation and the maintenance of the phenomenon. I would speculate that dorsal nerve block interrupts the afferent limb of a terminal facilitatory feed-back arc that sustains erection and that the technique might fail if overwhelmed by the other influences.

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