

References

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Favourable evolution of a deep humeral thrombophlebitis after paraffin oil injection

To the Editor:

To our knowledge, the effects of *iv* injection of paraffin oil had not been reported prior to our recent publication.¹ We wish to report on the long term follow-up of this unusual case.

A young man, age 18 yr, injected himself 2.5 mL of paraffin oil in the right humeral vein. Thrombophlebitis and thrombosis of the deep humeral vein ensued, treated initially with *iv* heparin, dexamethasone and antibiotics. Oral anticoagulant and anti-inflammatory treatment was pursued orally after discharge. The patient abandoned the treatment five months later. On follow-up 13 months after the event, clinical examination was essentially normal and a repeat phlebography showed a 50% reperfusion of the venous vasculature. (Figure).

Paraffin oil is irritating for the skin and mucous membranes. Its subcutaneous injection results in tissue necro-

sis and abscess formation.^{1–4} Ingestion and/or inhalation of the substance can lead to coma.^{4,5} Despite the *iv* injection of 2.5 mL of paraffin oil, no effects on the central nervous system were noted, possibly because the intense pain on injection limited the amount infused.

The subcutaneous injection of petroleum distillates produces vein thrombosis by contact.³ Direct *iv* injection resulted in more severe and extensive deep vein thrombosis. Despite therapy and partial recuperation of the venous circulation, thrombosis of the humeral vein was irreversible. Had the patient pursued treatment, venous reperfusion may have been more complete. However, functional recuperation was good.

We believe prompt and sustained treatment with anti-coagulants and anti-inflammatory drugs contributed to the favourable outcome observed in this case.

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FIGURE Phlebography 31 days and 13 months after the injection of paraffin oil in the right humeral vein: the deep humeral vein remained thrombosed. On follow-up at 13 months, the radial, inter-osseous and cubital veins were reperused.

Lightwand intubation using the Trachlight: a brief review of current knowledge¹

To the Editor:

I enjoyed reading the review by Agrò *et al.* concerning intubation with the Trachlight™ lighted stylet.¹

The Halifax group deserves great credit for designing and popularizing this instrument.

I believe the lighted stylet is the method of choice for elective intubations and is often the best solution for various types of difficult intubations. As a result of 12 years experience with lighted stylets,² I would suggest to your readers that they try an alternative technique for intubation with the Trachlight™.

I teach my students to use the same 'sniffing' position as they would with a laryngoscope. The tube is introduced from the right corner of the mouth with the tongue out of the way to the left. There is no need to put a hand into the patient's mouth. When learning the technique and for difficult cases a darkened room can be very helpful.

We use about a 75° bend at the tip of the tube. The handle of the Trachlight™ is held like a dart or a cigar. If the tube doesn't fall into place, one of three gentle manoeuvres may be required. If the light is in a pyriform fossa, the handle is rolled between thumb and fingers which sweeps the light sideways in front of the larynx until it shines brightly through the cords. If the light is in the esophagus, the tube is withdrawn slowly while keeping the tip pushed forward. It will then pop through the cords. Occasionally, a gentle forward thrust by an assistant on the angles of the jaw will be helpful.

Advancing the tube and withdrawing the stylet in one motion saves time. This is analogous to advancing an *iv* cannula and withdrawing the needle in one motion.

I encourage everyone to try both methods. Some will prefer the Halifax method and others the Vancouver method.

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REPLY:

We thank Dr. Graham for his interest in our paper entitled "Lightwand intubation using the Trachlight: a brief review of current knowledge".¹ We are delighted in acknowledging Dr. Graham's clinical experience regarding an alternative technique for intubation with the Trachlight™ (TL). During the last few years, many studies have confirmed the usefulness of the TL as a semi-

blind and easy to use technique for tracheal intubation in case of difficult laryngoscopy.²⁻⁴

Notwithstanding Dr. Graham's suggestions, we investigated a combined technique (direct laryngoscopy and TL) for patients in whom a Cormack grade 3 laryngoscopic view was simulated. We will submit the results of our study for publication in the near future. We noticed that the probability of successful tracheal intubation using the combined technique (direct laryngoscopy and TL) is higher than when direct laryngoscopy or TL are used separately.

A multicentre study to evaluate the efficacy of the Trachlight™ in difficult tracheal intubations is warranted.

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Ropivacaine is not the S-isomer of bupivacaine

To the editor:

In their recent paper, Lim *et al.* incorrectly referred to ropivacaine as the S-isomer of bupivacaine.¹

Ropivacaine and bupivacaine are amino-amide local anesthetics belonging to the piperidylidide group.² A propyl or butyl group on the piperidine nitrogen atom distinguishes the two; ropivacaine being the former and bupivacaine the latter.²

These local anesthetics are chiral compounds.² Although ropivacaine is a S (-) isomer, levobupivacaine is the true S (-) isomer of racemic bupivacaine.³

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