some hemodynamic variables, myocardial metabolism and regional myocardial blood flow during ischemia. *J Mol Cell Cardiol* 1979; 11: 47.

REPLY

Dr. Freysz et al. rightly point out that propofol (Diprivan®) may be added to the list of anaesthetic drugs which may result in bradyarrhythmias, particularly when used in association with cholinergic stimulating drugs like succinylcholine or neostigmine. Baraka¹ has suggested that propofol may lack the central vagolytic properties which the barbiturates possess. Based on the study of a pharmacologically denervated dog, Colson et al.² make the stronger suggestion that propofol may slow the heart directly. The occasional bradyarrhythmias experienced with propofol suggest that it would generally be wise to use anticholinergic premedication where fast heart rates are not problematic, especially in vagally stimulating procedures such as laparoscopy.³

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Intra-arterial verapamil to reverse acute ischaemia of the hand after radial artery cannulation

To the Editor:

A 67-yr-old male presented for left lower lobectomy for lung cancer after a history of progressive dyspnoea, cough and haemoptysis of six months' duration. Premorbid history noted heavy cigarette and alcohol use as well as Raynaud's phenomena involving both hands. Preoperative evaluation included a modified Allen's test and Porch test¹ using pulse oximetry to assess the collateral circulation of the hand. Both tests were negative. Intraoperatively, an Arrow #22 percutaneous catheter was inserted into the left radial artery atraumatically. Upon arrival in the ICU postoperatively, the patient developed acute ischaemia of the left hand shown by decreased arterial saturation involving all digits. The radial arterial line was aspirated and no air or clot was noted. Heparin 100 U was initially flushed through the radial arterial line with

no improvement. Verapamil 1 mg diluted in 3 ml normal saline was flushed through the arterial-catheter. Within five minutes, reactive hyperaemia was noted which correlated with concomitant increases in arterial saturation of the involved digits. It was concluded that arterial spasm was the likely cause of the ischaemia in view of the history of Raynaud's phenomena. This case demonstrates the effectiveness of intra-arterial verapamil in the treatment of acute arterial ischaemia of the hand secondary to Raynaud's phenomena. It also demonstrates the ability of the PORCH test in detecting but not predicting ischaemia.

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Eligibility of Canadians for the ASA overseas teaching program

To the Editor:

When the Overseas Teaching Program (OTP) sponsored by The American Society of Anesthesiologists (ASA) and the Foundation for Anesthesia Education and Research (FAER) was inaugurated in January, 1990,¹ criteria of eligibility for those wishing to serve as volunteers teaching anaesthesia in an undeveloped country were described as including membership in the ASA, certification by the American Board of Anesthesiology (ABA), and residence in the USA. These criteria need amplification. Applicants do have to be members of the ASA, but that includes affiliate members. Also, certification as a qualified specialist in anaesthesia can be either by the ABA or by an equivalent certifying body. Finally, residence must be in North America, not just in the USA. Many Canadian anaesthetists are thus eligible to serve as OTP volunteers.

The what, why, how and where of OTP are described in the 1990 announcement of the program.¹ Suffice it to say that OTP's objective is to contribute to the quality of patient care in developing countries by increasing the