REPLY

We appreciate this opportunity to respond to the observations made by Dr. K.R. McCaskill, concerning the Polamedco line of endotracheal tubes featuring the Sureloc external connector. The connector is fitted over the tube allowing for maximal lumen which translates into greater airflow capacity especially in the neonatal tube styles.

The connector is designed to travel down the tube with a "push-twist" motion to facilitate cutting the tube to a specific desired length, without the need to remove the connector from the tube as with internal connectors. When attaching air circuitry or a resuscitator to the Sureloc external connector, the anaesthetist or EMS professional grasps the connector (not the tube), just behind the connector's large wings and securely makes the connection. In this manner, the tube does not travel past the proximal end of the connector to the point of occluding either the resuscitator or ventilator.

In considering the incidents reviewed by Dr. McCaskill, and in light of the fact that not all medical personnel have been exposed to training sessions regarding the use of the Polamedco external connector, Polamedco has determined that the placement of a positive stop around the outer diameter of the tube will address the concerns of Dr. McCaskill and other emergency and anaesthesia professionals. With our flanged proximal tip to prevent tube-connector disconnect, and the addition of a positive connector stop approximately one inch down from the proximal end of the tube to limit connector travel, Polamedco will continue to provide one of the safest endotracheal tube lines in medical use today.

We appreciate Dr. McCaskill's observations, and look forward to responding to the needs of the medical community both foreign and domestic.

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No more blood patch in cancer patients

To the Editor:

It was very surprising to read the letter of Drs. Sher, Amar and Wollner¹ concerning the use of an extradural blood patch in a 19-yr-old girl with embryonal cell rhabdomyosarcoma.

They stated their concerns of the "risks of seeding the neuraxis with neoplastic cells." However, they retracted after the oncologist told them that the patient had "a well-localized tumour." How could he know? Who will stand in court if the patient has seeding of neoplastic cells in her epidural space? The oncologist or the anaesthetist? They also told the family of their concerns but the "patient requested a patch" – and they performed it. Did the patient know of all the other options to alleviate her post-spinal headache?

In their "research" of the literature they found only two alternative therapies for post-spinal headache: extradural saline infusion and caffeine. Tourtellotte in his book published 28 yr ago mentioned 49 modalities of treatment of post-spinal headache.²

Before advocating a blood patch for a cancer patient with the risk of seeding the neuraxis with neoplastic cells, it is better to use other modalities. Recently, we were successful in treating a group of patients with post-spinal headache by repeated intramuscular analgesic injections.

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REFERENCES

- 1 Scher CS, Amar D, Wollner N. Extradural blood patch for post-lumbar puncture headaches in cancer patients. *Can J Anaesth* 1992; 39: 203–4.
- 2 Tourtellotte WW, Haerer AF, Heller GG, et al. Post lumbar puncture headaches. Springfield, Illinois, Charles C. Thomas, Publisher, 1964.

Propofol and chemotherapy emesis

To the Editor:

We read with interest the recently published clinical reports of Scher *et al.*¹ on the use of propofol in the context of chemotherapy-associated nausea and vomiting. We feel that several points need to be raised on this subject.

- 1 The authors speculate that propofol may possess intrinsic antiemetic properties. We were recently able to demonstrate in a prospective, randomised, placebo-controlled double-blind study that propofol, used in sub-hypnotic doses for early postoperative vomiting, does possess intrinsic, direct antiemetic properties.²
- 2 The cases described are certainly interesting and gratifying in their success. However, it is surprising that an experimental treatment such as propofol infusion was instituted without first having tried maximal "state-of-the-art" antiemetic regimes³ (e.g., 5-HT₃ antagonists with or without corticosteroids.)
- 3 Chemotherapy with high-dose methotrexate, cyclophosphamide or isophosphamide is generally regarded as being only moderately emetogenic. High-dose cisplatin-based chemotherapy (> 120 mg · m⁻²) is the most eme-