Correspondence

Availability of dantrolene in Canadian hospitals

To the Editor:

We read with interest Duncan's editorial on the availability of dantrolene in Canadian hospitals.¹ Two years ago we wrestled with this problem when we were requested by the Alberta Medical Association to make a recommendation on how much dantrolene should be available in each hospital. Our conclusion was similar to Duncan's: that 12 vials, containing a total of 240 mg of dantrolene, should be the minimum amount, with more available within a short time. Two hundred and forty mg would provide an initial dose of 3 mg·kg⁻¹ for patients weighing up to 80 kg.

We have reviewed some of the case reports of malignant hyperthermia occurring after dantrolene prophylaxis.^{2,3} Often it is difficult to determine the precise dosage regimen from the report,³ and it is our feeling that adequate tissue levels have not been achieved in many of these cases. Administration of intravenous dantrolene immediately preoperatively,⁴ although expensive, may eliminate the occurrence of reactions after oral dantrolene pretreatment, and this is now our practice. Intravenous administration also eliminates the unpleasant side effects (weakness, blurred vision and nausea) of oral dosage over one or two days.

Overall, routine intravenous prophylaxis with an adequate dantrolene dose (2.5–3.0 mg·kg⁻¹) may be cheaper than treating occasional malignant hyperthermia reactions.

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Massive haemorrhage during attempted laparoscopy

To the Editor:

Massive haemorrhage is a recognised complication of laparoscopy. Puncture of the distal aorta¹ or the iliac vessels² and tearing of the broad ligament³ by the laparoscopic trocar or gas insufflation needle have been reported. Fortunately the incidence of haemorrhage is low. It has been reported as 0.64 per cent by Phillips⁴ who reviewed 100,000 pelvic laparoscopies.

We encountered a case of massive haemorrhage during attempted laparoscopy. A 33-year-old 60 kg female, ASA physical status I underwent general anaesthesia with endotracheal intubation for a scheduled laparoscopic tubal ligation. As the intra-umbilical skin incision was made, a gush of blood was seen. Immediate pressure over the incision stopped any evidence of external bleeding. However, over the next three minutes the patient's vital signs deteriorated with an elevation in heart rate and a nonpalpable pulse. Immediate cardiopulmonary resuscitation was begun and emergency laparotomy quickly followed. A four millimeter laceration of the left common iliac artery just below the bifurca-