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Ciguatera and the anesthesiologist

To the Editor:

Recently, we anesthetized a man recovering from ciguatera. Although ciguatera is the most frequently reported food-borne disease due to chemical toxicity in the United States, there are no reports regarding the anesthetic management of patients suffering from this condition.¹

Ciguatera results from the consumption of coral reef-associated fish contaminated by ciguatoxins. The symptoms can occur 10 minutes after ingestion of contaminated fish and include weakness, myalgia, vomiting, paresthesias and paradoxical reversal of temperature perception. Severe cases may present coma and respiratory paralysis. Recovery may take years.²

Ciguatoxins trigger persistent sodium channel opening in excitable membranes. This results action potentials oscillations which cause bursts of spontaneous discharges. Manifestations of central nervous system involvement is only seen in severe cases.³ For the acute intoxication, mannitol is the treatment of choice but there is no specific therapy for the chronic condition.⁴

Our patient had a cholecystectomy. Six months earlier he suffered a severe ciguatera intoxication. He still complains of severe muscle pains and weakness.

The patient was anesthetized with midazolam, propofol, fentanyl, desflurane and rocuronium. The neuromuscular block was reversed with neostigmine and glycopyrrolate. We avoided succinylcholine because of the possibility of exacerbating the myalgias. Epidural analgesia was also avoided as not to confuse further evaluation of the patient's lower limb weakness and pains. The procedure was uneventful and the patient recovered without complications.

However, the pathophysiology of ciguatera poisoning suggests multiple anesthetic implications. Considering that the incidence of ciguatera is rapidly increasing, it behooves anesthesiologists to be familiar with this entity.

Rafael A. Ortega MD
Navinderdeep Singh
Ricarda Peine

Department of Anesthesiology
Boston University School of Medicine
88 East Newton Street
Boston, MA02118

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Chewing gum prior to anaesthesia – is not age restricted

To the Editor:

Patients are advised to refrain from chewing gum before anaesthesia. This is based on the fear that it might increase acid gastric secretion,^{1,2} gastric volume,³ and endotracheal tube obstruction.⁴

An 81-yr-old woman (ASA II) was scheduled for general anaesthesia for exploratory laparotomy. In the preoperative interview, no abnormality was noted as to her speech. No loose teeth were seen or reported. She had a full mobility of her tongue and the tip of the uvula was clearly seen. The airway was assessed as a class 1. The patient was taken to the operating room and monitors placed. Preoxygenation was commenced, but prior to the anaesthetic induction with thiopentone, the patient asked "Is it time for me to take my chewing gum out?" We suggested that it was, and a wad of gum (2 cm in diameter) was removed. Needless to say much to our surprise, as neither the preoperative staff nor ourselves had noted anything strange about her speech, nor saw her chewing. A potentially fatal airway obstruction could have ensued.⁴

Renae Tays MD
John G. Brock-Utne MD PhD FFA (SA)
Anesthesia Department, H3580
Stanford University Medical Center
Stanford, CA 94305-5115

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