Correspondence

Persistent perioperative laryngospasm in a patient with Parkinson's disease

To the Editor:

A 61-yr-old man with Parkinson's disease (PD) had surgery for a perianal abscess. He was wheelchair bound, had impaired speech but no dyspnoea, upper airway obstruction or dysphagia. He had a receding chin, and limited jaw movement due to previous surgery. Treatment with Sinemet (levodopa and carbidopa), benzhexol and bromocriptine was continued throughout the perioperative period.

General anaesthesia was induced with propofol, and maintained with sevoflurane and fentanyl. As anaesthetic depth increased, he developed airway obstruction. An oropharyngeal airway was inserted. This and surgical stimulation caused laryngospasm, which lessened as anaesthetic depth was further increased. At laryngoscopy, only the epiglottis could be seen. The oropharynx was clear. Laryngospasm persisted and worsened after surgery and full awakening. Awake blind nasal intubation immediately relieved airway obstruction and he could then breathe well. We avoided muscle relaxants as conventional intubation would have been difficult. His chest was clear and he had no new neurological signs.

On extubation 24 hr later, laryngospasm recurred. Fiberoptic laryngoscopy showed the vocal cords adducting during inspiration. There was no airway inflammation or lesion. As laryngospasm worsened, the trachea was re-intubated, Sinemet dosage was doubled and uneventful extubation was performed 24 hr later.

Primary laryngospasm is a known complication of PD^{1,2} and acute withdrawal of treatment can cause airway obstruction.³ While laryngospasm in this patient was triggered by airway stimulation, persistent laryngospasm was due to inadequate treatment. While seemingly adequate treatment was not interrupted, an increased dosage was required to relieve laryngospasm. Parkinsonian patients may need optimization of their treatment during an acute infection and in the perioperative period to prevent persistent laryngospasm.

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Another potential problem with the "hidden iv"

To the Editor:

Surgeons often request one or both arms tucked beside the anesthetized patient's body during surgery. The *iv* catheter, as it enters the vein, is therefore hidden from view. Serious complications can arise when the *iv* insertion site is hidden. One of the more serious being the infiltration of fluids into the hand/arm. One of the authors (JGBU) has seen a case where the arm above the elbow had to be amputated following a five hour cardiac bypass procedure. We recently had another potential problem with the "hidden *iv*" which we believe is unreported.

A 55-yr-old man was scheduled for emergency laparotomy. He arrived in the operating room with a 20G *iv* catheter in his left hand. This was seen to be working adequately and general anaesthesia was induced in a routine manner using this line. After induction, a 14G peripheral *iv* and a central vascular line were inserted into the right subclavian vein without any problems. The left arm, with the 20G *iv*, was tucked alongside the patient's body. During the operation, renal dose dopamine was needed. We elected to use the central line instead of the 20G *iv* line which, incidentally, was seen to be working well. The urine output improved and the patient was taken to the recovery room, awake and cooperative with stable vital signs. Here we discovered that, 20 cm from the insertion of the 20G *iv*, the intravenous line was cut. The distal end, attached to the 20G *iv* catheter, had a tight knot while the proximal end was open. We now