Twenty minutes later, anaesthesia was again induced using the same agents. Myoclonic jerking of the legs again appeared three minutes after induction. It was noted that these jerking movements were exacerbated by tactile stimulation of his shoulders. The operation was canceled. Infusion of propofol was terminated and the patient awakened shortly without any neurological deficits. After regaining consciousness, myoclonic jerking was not observed. Magnetic resonance imaging scan of the spinal cord was normal.

The patient underwent shoulder surgery 12 days later under brachial plexus block and propofol infusion. The myoclonic movements of his legs appeared shortly after induction and persisted during two hours of surgery. Recovery was uneventful and myoclonus was not observed after the patient awakened.

Our patient was fully awake and alert after each of three anaesthetics and showed no post-ictal state, which makes the diagnosis of seizure unlikely. Intraoperative movements of his legs were most likely to be spinal myoclonus, a result of inhibition of supraspinal control. It is suggested that subcortical excitatory-inhibitory centre imbalance may persist during maintenance with propofol infusion.¹⁻⁴

Shuya Kiyama MD
Tamotsu Yoshikawa MD
Department of Anaesthesia
Shizuoka Red Cross Hospital
8-2 Ohtemachi, Shizuoka, 420, Japan.

REFERENCES

- 1 Borgeat A, Dessibourg C, Popovic V, Meier D, Blanchard M, Schwander D. Propofol and spontaneous movements: an EEG study. *Anesthesiology* 1991; 74: 24-7.
- 2 Sutherland MJ, Burt P. Propofol and seizures. *Anaesth Intensive Care* 1994; 22: 733-7.
- 3 Finley GA, MacManus B, Sampson SE, Fernandez CV, Retallick R. Delayed seizures following sedation with propofol. *Can J Anaesth* 1993; 40: 863-5.
- 4 Bevan JC. Propofol-related convulsions (Editorial). *Can J Anaesth* 1993; 40: 805-9.

Intravenous obstruction and PCA machines

To the Editor:

Several PCA overdoses have been reported,¹⁻⁵ but I wish to report a near fatality from an unusual cause.

A 65-yr-old obese lady underwent right total knee replacement. A PCA pump (Abbot Lifecare 4100 PCA plus 11 inhaler) was ordered after the epidural analgesia

had been discontinued. Meperidine was prescribed with: bolus 20 mg; lock-out - eight minutes; total four hour maximum - 300 mg total. Surgery and anaesthesia were uneventful and the patient returned to the floor at about 1600. She complained of pain in the knee all afternoon and evening and continued to push the PCA button without relief. At 0025 the following morning, it was noted that the *iv* infusion had gone interstitial. At 0210 the *iv* site was changed, the tubing was reconnected but, very rapidly, the patient became cyanotic and suffered a respiratory arrest. With naloxone and positive pressure ventilation, the patient was successfully resuscitated and transferred to the ICU for observation.

The message is that the patient's *iv* had been occluded at the skin site for some time and the opioid accumulated in the *iv* double lumen bag. Opioid accumulated in the *iv* bag throughout the afternoon and evening, the safety features of the PCA machine were bypassed and the patient received a potentially lethal dose of opioid when the *iv* was reconnected to a new cannula. Our *iv* nurses now change the *iv* tubing and solution when re-establishing an *iv* infusion that has a PCA pump attached.

James G. Paterson MD
North York General Hospital
Toronto, Ontario

REFERENCES

- 1 Barnes N, Strong T, Taylor T. Respiratory arrest with patient-controlled analgesia (Letter). *Anaesth Intensive Care* 1996; 24: 117-9.
- 2 Simes D, Power L, Priestley G. Respiratory arrest with patient-controlled analgesia (Letter). *Anaesth Intensive Care* 1995; 23: 119-20.
- 3 Southern DA, Read MS. Overdosage of opiate from patient-controlled analgesia devices. *BMJ* 1994; 309: 1002.
- 4 Etches RC. Respiratory depression associated with patient-controlled analgesia: a review of eight cases. *Can J Anaesth* 1994; 41: 125-32.
- 5 Kwan A. Morphine overdose from patient-controlled analgesia pumps. *Anaesth Intensive Care* 1996; 24: 254-6.

Intrapleural placement of a nasogastric tube

To the Editor:

We read with interest the case report "Intrapleural placement of a nasogastric tube: an unusual complication of nasotracheal intubation."¹ The authors believed that several factors may predispose to oesophageal perforation by nasogastric tubes includ-