Paroxysmal sneezing during local anesthesia for ocular surgery with thiopentone hypnosis

To the Editor:

Severe sneezing after local anesthetic injection during intravenous propofol hypnosis has been linked with the ACHOO (Autosomal dominant Compelling Heliotropic Ocular Outburst) reflex.¹ The same response was noted in two asymptomatic patients without history of allergies or epilepsy (a 68 yr white man for cataract surgery, and a 65 yr white woman for supraciliary brow ptosis repair) during thiopental (Pentothal, Abbott Laboratories, North Chicago, IL) hypnosis. Before waking up both patients vigorously sneezed repeatedly after local anesthetic injection of bupivacaine 0.5% (Marcaine, Astra, and Westborough, MA) and lidocaine 2% with epinephrine (Lignocaine, Astra, Westborough, MA) with hyaluronidase (Wydase, Wyeth-Ayerst, Philadelphia, PA) given with a 1½ inch and ½ inch 25 gauge needle (Beckton Dickinson and Company, Franklin Lakes, NJ) transcutaneously. Both had a strong family and personal history of photic sneezing.²

These cases demonstrate additional features to this response: the sneezing may occur with many hypnotic agents, including propofol, thiopentone and chlormethiazole,³ it may occur after injections inside the muscle cone and outside the orbit. It may occur without pupillary dilation or lid elevation, excluding a strong light stimulus as sole cause.⁴ Since it occurred after needle withdrawal, a sharper needle might not avoid the problem.

Awareness of this phenomenon (and its predisposition) may facilitate recognition and prompt needle withdrawal (or using a flexible cannula)⁵ to avoid serious problems from sudden head movements during injection or inappropriately administering additional therapy. Alternately, vigorous rubbing of the patient's nose may abort the sneeze. (Personal communication, Venkata Baredy MD, 1998)

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Laryngoscopy for pediatric laryngeal mask airway insertion

To the Editor:

It has been my experience that insertion of the laryngeal mask airway in children is associated with low morbidity when performed under direct vision.

There are two main advantages with this technique. Firstly, use of the Miller straight blade to lift the relatively large, floppy epiglottis of the infant allows the LMA mask tip to slide naturally behind it. This minimizes inadvertent backward folding of the epiglottis and attendant airway obstruction. A second benefit is that of reduced trauma to the tonsils. Children in the two to five year age group have tonsillar hypertrophy, sometimes associated with infection. Bleeding from traumatized tonsils may result in stridor and laryngospasm, particularly during emergence.

This technique is easily learnt. In principle it entails establishing an adequate depth of anesthesia either intravenously or by inhalation, a well-lubricated mask and familiarity with pediatric laryngoscopy. Muscle relaxants are unnecessary unless specifically indicated.

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