Correspondence

Dystonic reaction after anesthesia

To the Editor:

A healthy 24-yr-old woman had a tonsillectomy under general anesthesia with propofol, mivacurium, air, O₂, isoflurane. She also received 4 mg ondansetron and bupivacaine 0.5% with epinephrine was injected into the faucial pillars as a prophylaxis for nausea, vomiting and postoperative pain. The procedure lasted 40 min and the trachea was extubated when she was awake. Fifteen minutes after arrival in PACU, she started to have dystonic movements affecting the upper limb, chest and lower limbs. The patient was awake and responsive and was very nervous. Vital signs were normal, temperature 37°C, BP 130/80, heart rate 120. She was given incremental doses of midazolam to 2 mg, but the dystonic movements persisted. The pupils were equal and reactive and patient had no pain. The differential diagnosis was adverse drug reaction, local anesthetic reaction, emergence delirium, hysterical response and post anesthetic shivering. Local anesthetic reaction is unlikely as only 5 ml bupivacaine were given. The possibility of adverse drug reaction to ondansetron or propofol was entertained. The dystonic movements lasted three hours. Neurological consultation was requested and was thought to be a psychogenic reaction.

Ondansetron produces dystonic reactions in chronic use¹ and propofol produces dystonic reaction, seizures and opisthotonus.^{2,3} Hysterical reaction and delirium usually respond to sedation. Post anesthetic shivering involves the whole body and is often associated with rigidity. There is a recent report of excitatory phenomena with propofol.⁴

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- 3 Saunders PRI, Harris MNE. Opisthotonus and other unusual neurological sequelae after outpatient anaesthesia. *Anaesthesia* 1990; 45: 552–7.

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On anesthesia services

To the Editor:

The paper by Le May¹ reveals disquieting gaps between title and content and misconceptions about the use of words. The title appears to address issues of *anesthesia service* but the questionnaire includes a question concerning “adequate” relaxation. This is not a “service” (such as billing from a credit card company) rather it is a subjective evaluation by one professional about the technical performance of another although the one making the judgement is not qualified to perform that same procedure. An inept surgeon who cannot develop adequate exposure will complain about relaxation even when the patient, the anesthesiologist and the circulating nurse are all drowning in a sea of curare. Such a questionnaire should have required each surgeon to rate each anesthesiologist progressively on a case by case basis. If all the surgeons complained about the same anesthesiologist one *might* have proved a point. However, if one surgeon had complained all the time about all of the anesthesiologists then the picture would be different.

Another issue raised was that of “providing stable conditions”. This is too vague to be quantified, again by somebody who is not qualified to perform that same procedure. Furthermore, at least with reference to the blood pressure, continuous automatic *monitoring and recording* has shown that instability of the blood pressure during anesthesia is the norm rather than the exception. The origin of the myth of the stability of the patient during anesthesia lies in the origin of the hand-made anesthesia record which in fact is a record of the anesthesiologist’s perception, and what controls it, rather than a true anesthesia record.

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Reference

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