

## Correspondence

### *Effusion after interpleural analgesia*

To the Editor:

Interpleural regional analgesia for postoperative pain relief is simple, safe and effective.<sup>1-2</sup> Pneumothorax is the most common complication.<sup>1-3</sup>

Following an elective cholecystectomy in a 29-yr-old healthy human but before extubation of the trachea, the patient was turned to the left side, and an interpleural catheter was placed using the saline infusion technique.<sup>4</sup> General anaesthesia was then discontinued, 20 ml of 0.5% bupivacaine with epinephrine ( $5\mu\text{g}\cdot\text{ml}^{-1}$ ) were injected and the patient had good pain relief. Nine hours later, when a top-up dose was needed, aspiration of the catheter yielded about 9 ml of hazy, red-tinged fluid. This was sent for examination and the top-up dose was withheld. Overnight the patient received meperidine and promethazine for pain relief. Re-aspiration of the catheter the next day produced no aspirate and interpleural analgesia was continued for a further 48 hr uneventfully using plain bupivacaine.

Examination of the aspirated fluid showed an RBC count of  $60,660\cdot\mu\text{l}^{-1}$  and WBC count of  $360\cdot\mu\text{l}^{-1}$  (differential leucocyte count from concentrated centrifuge was neutrophils 50%, lymphocytes 13%, monocytes 31%, eosinophils 3% and bands 3%).

The mechanism of this effusion is unclear. It could have been a reactionary pleural effusion to the catheter or to sodium metabisulphite and anhydrous citric acid which are added as antioxidants when epinephrine is added to bupivacaine. Subsequent use of plain bupivacaine produced no such effusion. Although no direct cause and effect relationship could be established from this case report, yet it highlights the need for vigilance.

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- 3 Ananthanarayan C, Kashtan H. Pneumothorax after interpleural block in a spontaneously breathing patient. *Anaesthesia* 1990; 45: 342.
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### *The laryngeal mask airway and fiberoptic laryngoscopy*

To the Editor:

Following a recent case of tracheal intubation using the Laryngeal Mask Airway<sup>®</sup> where other means had failed,<sup>1</sup> we postulated that the Laryngeal Mask Airway might prove an effective means of holding the tongue forward and centrally positioning the fiberoptic bronchoscope during elective fiberoptic tracheal intubation.

The method currently used at our institution consists of fiberoptic bronchoscope insertion through a Williams Airway Intubator<sup>®</sup> with subsequent endotracheal tube insertion through this airway over the fiberoptic bronchoscope.

Patients who were scheduled to undergo elective surgery with general anaesthesia were selected and informed consent was obtained. The patients' airways were evaluated according to Mallampatti classification and general anaesthesia was induced. Either the Williams Airway Intubator<sup>®</sup> or Laryngeal Mask Airway<sup>®</sup> was inserted in random order, a fiberoptic bronchoscope was then directed to the laryngeal inlet, and the time to first view of the cords was recorded by an independent observer monitoring the procedure on a screen.

Our results suggest that the Laryngeal Mask Airway<sup>®</sup> was as effective as the Williams Airway Intubator<sup>®</sup> for quickly directing the fiberoptic bronchoscope to the vocal cords ( $P - NS$ ).

|             | LMA  | TWA  |
|-------------|------|------|
| <i>n</i>    | 14   | 14   |
| Range (sec) | 3-45 | 2-50 |
| Mean (sec)  | 8.9  | 12.9 |
| SD          | 10.3 | 15.6 |