

# Correspondence



## *Phosphate salt bowel preparation regimens alter perioperative acid-base and electrolyte balance*

To the Editor:

Ezri *et al.*<sup>1</sup> described serum electrolyte changes following ingestion of cathartics prior to bowel resection surgery. The authors dosed 90 mL of Fleet® Phospho-soda® to their subjects. This is twice the recommended dose of 30–45 mL according to the current professional Fleet® Phospho-soda® labeling.<sup>2</sup> Fleet® Phospho-soda® should be used only at the recommended dosage and only in patients that do not have contraindications to the drug product.

Michael Caswell PhD

Fleet Laboratories, Lynchburg, USA

E-mail: caswellm@cbfleet.com

Accepted for publication May 5, 2006.

### References

- 1 Ezri E, Lerner E, Muggia-Sullam M, *et al.* Phosphate salt bowel preparation regimens alter perioperative acid-base and electrolyte balance. *Can J Anesth* 2006; 53: 153–8.
- 2 Murray L. *Physician's Desk Reference*, 60<sup>th</sup> ed. New Jersey: Thompson Healthcare, Inc.; 2006: 1170–2.

### Reply:

We would like to thank Michael Caswell, PhD, for his important observations regarding the dose and contraindications to the use of sodium phosphate salts for bowel preparation prior to surgery.

First, as we stated in our manuscript, the drug was not used in cases where it was contraindicated.<sup>1</sup> Secondly, although we did use 90 mL of solution, we prescribed the medication in two doses, separated by an eight-hour interval. While the time interval between the administration of doses varies amongst studies, a 90 mL volume, administered in two separate doses is recommended in the drug leaflet (Soffodex by Dexxon Ltd, Or-Akiva, Hadera, Israel) and several recently published studies.<sup>2–4</sup>

Tiberiu Ezri MD\*

Peter Szmuk MD†

Michael Muggia-Sullam MD\*

Wolfson Medical Center, Holon, Israel\*

University of Texas Medical School and

Children's Medical Center at Dallas,† Dallas, USA

### References

- 1 Ezri T, Lerner E, Muggia-Sullam M, *et al.* Phosphate salt bowel preparation regimens alter perioperative acid-base and electrolyte balance. *Can J Anesth* 2006; 53: 153–8.
- 2 Muzii L, Bellati F, Zullo MA, Mancini N, Angioli R, Panici PB. Mechanical bowel preparation before gynecologic laparoscopy: a randomized, single-blind, controlled trial. *Fertil Steril* 2006; 85: 689–93.
- 3 Delegge M, Kaplan R. Efficacy of bowel preparation with the use of a prepackaged, low fibre diet with a low sodium, magnesium citrate cathartic vs. a clear liquid diet with a standard sodium phosphate cathartic. *Aliment Pharmacol Ther* 2005; 21: 1491–5.
- 4 Huppertz-Haus G, Bretthauer M, Saunar J, *et al.* Polyethylene glycol versus sodium phosphate in bowel cleansing for colonoscopy: a randomized trial. 2005; 37: 537–41.

## *The ProSeal LMA does not cause laryngeal edema*

To the Editor:

We were intrigued by the case report by Chin and Chee<sup>1</sup> but have doubts about whether the authors properly interpreted the fiberoptic image they presented. Because the entire case report is built upon the premise that this image portrays “laryngeal edema,” an improper interpretation would jeopardize not only their diagnosis, but also the rationale for treatment with dexamethasone and further explanation of intraoperative events.

We suggest a more likely interpretation of the fiberoptic airway examination in patients with a ProSeal™ laryngeal mask airway (PLMA; LMA North America, Inc., San Diego, CA, USA). Figures 1 and 2 show, in the absence of “laryngeal edema,” the more common problem of mechanical obstruction of the laryngeal inlet by the cuff and drain tube of the PLMA.<sup>2,3</sup>