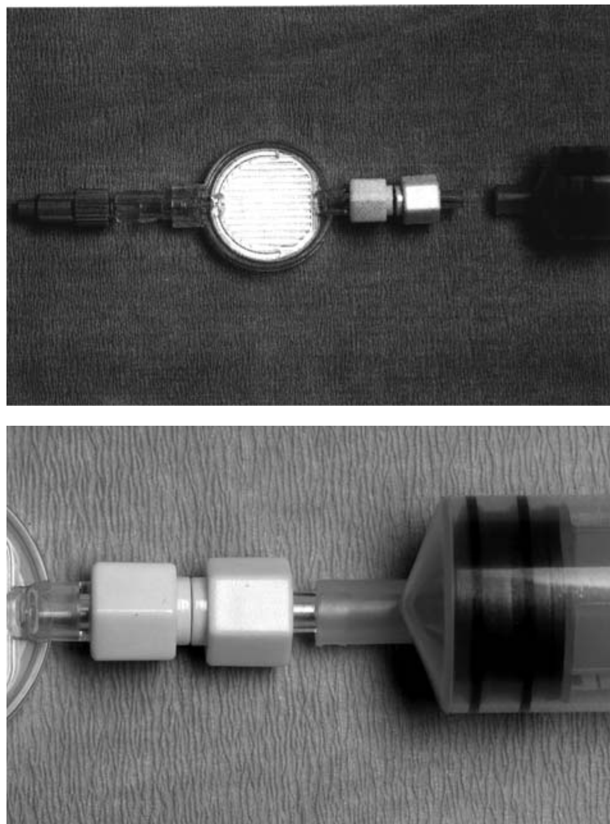

FIGURE A and B Vygon epidural infusion set with female Luer Lock connector.

References

1 *Mahajan R*. Avoiding the accidental iv injection of local anesthetics (Letter). Can J Anesth 2003; 50: 1077–8.

2 *Favier JC, Da Conceicao M, Fassassi M, Allanic L, Steiner T, Pitti R*. Successful resuscitation of serious bupivacaine intoxication in a patient with pre-existing heart failure. Can J Anesth 2003; 50: 62–6.

REPLY:

We would like to thank the authors for their interest in our correspondence and for making a couple of points to avoid the accidental iv administration of local anesthetics. We do concur with the authors that "to err is human" and applaud the novel innovation of the Vygon epidural infusion set incorporating an easy Luer adaptor with syringes with a female Luer Lock.

However, we don't agree with the authors that colour is a too subtle characteristic to be relied upon. Prepackaged plastic syringes with distinct colour of the plunger with both horizontal and vertical flanges are available with Portex™ and B/Braun™ epidural sets. Colour coding of the syringe labels is recommended by various trials and surveys as a visual alarm to avoid syringe swaps.[1–3] Although one can overlook or ignore the colour of small labels when in haste,[4] we firmly believe that there is far less chance of doing so with uniformly coloured plungers, especially when used routinely. However, a formal evaluation assessing the impact of syringes with distinct coloured plungers for epidural use is still awaited.

Prepackaged epidural sets are available without the loss of resistance plastic syringes. Glass syringes are routinely used for this purpose in our institution. If maintained scrupulously, these can be excellent.[5] Further, the weight of glass syringes is as discernible to the educated hand as is the colour to the eye.[5]

In conclusion, we would reiterate that the feel or pressure of syringe plungers or the colour of the plungers and weight of glass syringes will continue to be reliable safe guards against accidental iv injection of drugs intended for neuraxial administration. However, one can speculate that safety will increase further with the adoption of dedicated connection systems.

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1 *Favier JC, Allanic L, Armees M*. Avoiding the accidental iv injection of local anesthetics (author reply). Can J Anesth 2003; 50: 1078.

2 *Radhakrishna S*. Syringe labels in anesthetic induction rooms. Anaesthesia 1999; 54: 963–8.

3 *Christie IW, Hill MR*. Standardized colour coding for syringe drug labels: a national survey. Anaesthesia 2002; 57: 793–8.

4 *Fasting S, Gisvold SE*. Adverse drug errors in anesthesia, and the impact of coloured syringe labels. Can J Anesth 2000; 47: 1060–7.

5 *Armitage EN*. Lumbar and thoracic epidural block. *In:* Wildsmith JA, Armitage EN, Mcclure JH (Eds). Principles and Practice of Regional Anaesthesia, 3rd ed. New York: Churchill Livingstone; 2003: 139–68.

REPLY:

We can only agree with LaRosa et al. The solution proposed to avoid the accidental iv injection is effective …for epidural catheters and lines. Unfortunately, this solution does not exist (in France) for dedicated nerve block needles (neurostimulation). This is why we use dedicated syringes (30 mL syringes in our institution) and specific labelling with grey colour labels (SODIS laboratories, Mulhouse, France).[1]