9th Anaesthesia Conference, Organised by British Association of Indian Anaesthetists, Holywell Park, Loughborough, Leicestershire, UK
2nd October 2010

Audit on Red Wrist Bands for Allergy

1S Shanmuganathan, 2K Wilkinson, 1V Angusamy
1Speciality Anaesthetics, Noble’s Hospital, Isle of Man, IM4 4RJ, UK
2Consultant Anaesthetist, Noble’s Hospital, Isle of Man, IM4 4RJ, UK

ABSTRACT

The purpose of the audit was to look at the inappropriate use of red wrist bands for allergy and to compare the results with a previous audit done in 2004. All patients coming to theatre for elective/emergency surgeries were included in the audit for a period of 3 months from August 2009 to October 2009. The audit was compared to the standards (local policy), which state that 100% of patients with genuine allergy should have a red wrist band, and 100% of health care professionals are aware of the difference between allergy and side effects. Out of total 314 patients, 153 patients had a red wrist band which constitutes 49% of the total. Out of the remaining 161 patients without red wrist bands, one patient had true allergy. Seventy two patients (47%) with red wrist bands had true allergy (for example, skin rash, urticaria, swelling of lips, difficulty in breathing due to bronchospasm, cardiovascular collapse). Thirty eight patients (25%) with red wrist bands were not considered by us to have true allergy (side effects/sensitivities). In 25 patients (16%), use of red wrist bands was considered inappropriate (substances not encountered in clinical setting for example, cat/dog furs, metals, pollens, etc.). For 18 patients (12%) with red wrist bands, there was uncertainty about their allergy (probable/possible allergy). When compared to the previous (2004) audit, there has been considerable improvement (20%) in appropriateness of having red wrist bands for patients with true allergy. Labelling patients as allergic when they did not came down from 48 to 25%. Sadly, inappropriate use (substances not encountered in clinical setting) of red wrist bands increased from 10 to 16%. In summary, the inappropriate use of red wrist bands came down from 58 to 41%. We feel that the inappropriate use of red wrist bands may lead to complacency, i.e. their importance/significance may be diminished, potentially leading to mistakes being made. The aim of this audit is to educate staff/patients by introducing allergy charts, clearly separate the side effects from true allergy, elicit a thorough history and also distinguish drug sensitivity from allergy in drug charts. It may be that there is a place for allergy testing in some patients who are uncertain about their allergy.

Audit on Red Wrist Bands for Allergy

1S Shanmuganathan, 2K Wilkinson, 1V Angusamy
1Speciality Anaesthetics, Noble’s Hospital, Isle of Man, IM4 4RJ, UK
2Consultant Anaesthetist, Noble’s Hospital, Isle of Man, IM4 4RJ, UK

An Interesting Case of Dyslipidemia for Caesarean Section

1Pranab Kumar, 2Mano Doraiswami
1Specialist Registrar, Department of Anaesthetics, Queens Hospital, Romford, Greater London, RM7 0AG, UK
2Consultant Anaesthetist, Department of Anaesthetics, Queens Hospital, Romford, Greater London, RM7 0AG, UK

INTRODUCTION

Dyslipidemias are a group of lipid metabolism disorders characterised by hypercholesterolemia or hypertriglyceridaemia or both. In vast majority of the patients, they are secondary to diet, sex, obesity, medications or other congenital disorders affecting lipoprotein metabolism. They can be monogenic or polygenic in origin.1 We present a case of a patient with type IV hyperlipoproteinemia (familial hyperlipemia) who presented for an emergency caesarean section.

CASE REPORT

A 29-year-old primigravida, in 37 + 4 weeks of gestation presented with symptoms of antenatal bleeding. She was not in labour and presented with shock, pallor and tachycardia (132 beats/min). Her abdomen was generally nontender, and initial point of care haemoglobin was 7.4 g/l.
Ultrasound showed the presence of fetal heart movements and complete placenta praevia. She was taken to theatres for a category 1 caesarean section. Rapid sequence induction was performed, and airway secured swiftly. The baby was delivered with cord gases within normal range. However, intraoperative period was complicated with atonic uterus. Invasive lines were inserted for cardiovascular instability. The blood was strikingly turbid and interfered with electrolyte abnormalities, and pH revealed severe metabolic acidosis. Hence, decision was taken to keep her ventilated postoperatively in ICU set-up. Working diagnosis of undiagnosed familial hyperlipemia was reported. Difficult gas analysis and glucose control required technical analysis from special apparatus. The baby was delivered with cord gases within normal range. Ultrasound showed the presence of fetal heart movements and complete placenta praevia. She was taken to theatres for a category 1 caesarean section. Rapid sequence induction was performed, and airway secured swiftly. The baby was delivered with cord gases within normal range. However, intraoperative period was complicated with atonic uterus. Invasive lines were inserted for cardiovascular instability. The blood was strikingly turbid and interfered with electrolyte abnormalities, and pH revealed severe metabolic acidosis. Hence, decision was taken to keep her ventilated postoperatively in ICU set-up. Working diagnosis of undiagnosed familial hyperlipemia was reported. Difficult gas analysis and glucose control required technical analysis from special apparatus. The patient deteriorated despite fluids and escalating inotropes. Acute renal failure developed and continuous venovenous haemofiltration and infusion of recombinant human activated protein C was started. Over the next 24 hours, he deteriorated further. An infusion of IVIG was initiated at a dose of 2 gm/kg. Within 12 hours of commencing infusions, there was a dramatic reduction in inotrope and fluid requirement enabling their complete withdrawal over the next 48 hours. The patient was discharged from hospital 1 month later without any evidence of persisting organ dysfunction.

CONCLUSION

To our knowledge, this is the first case report to demonstrate such a rapid haemodynamic improvement following infusion of IVIG in the treatment of STSS.

REFERENCES

Unusual Anaesthetic Technique for Microlaryngoscopy and Vocal Cord Biopsy

Belliappa U, Bedayse N, Pradhan P, Prabhu A
Department of Anaesthetics, Diana Princess of Wales Hospital, Grimsby, UK

INTRODUCTION
The commonly used anaesthetic technique for microlaryngoscopy is general anaesthesia with endotracheal intubation with a MLT-cuffed tracheal tube. Ventilation could be spontaneous, controlled or with jet ventilator. We describe a case, where an adult patient was maintained breathing spontaneously with target-controlled infusion (TCI) of propofol, and TCI of remifentanil without endotracheal intubation for microlaryngoscopy and removal of a mass between the vocal cords.

CASE HISTORY
An 87-year-old gentleman with history of COPD, presented with a 6 months history of hoarseness of voice. On nasoendoscopy, a mass was found between his vocal cords. A CT scan of his neck on the operation day showed a focal thickening of right true vocal cord with lobulated margin hanging in to the supraglottic space and irregular thickening of median glossoepiglottic fold. His airway assessment was normal. Patient had respiratory wheeze bilaterally. His SpO₂ reading was 94% on room air.

PROCEDURE
Patient was anaesthetised on the operating table. After preoxygenation, anaesthesia was commenced with remifentanil effect site TCI of 1.0 ng/ml and propofol plasma TCI of 1.0 mcg/ml. Gradual increments of 0.5 units were made with the aim of maintaining spontaneous breathing. Throughout the operation, patient continued to receive oxygen with nasal canula at 4 litres per minute, and oxygen saturation was maintained at 95% or more. Microlaryngoscopy was performed, necrotic slough between the cords removed and biopsy from the right vocal cord taken. Patient was then woken up. He developed laryngospasm at the end of operation which was successfully treated with mask CPAP. In total, patient received 121 mcg of remifentanil and 159 mg of propofol over a period of 15 minutes.

DISCUSSION
In this case, awake fibre-optic bronchoscope guided intubation was not considered because of the possibility of total airway obstruction. Although intubation with a MLT tube after direct laryngoscopy was plan B, we wanted primarily to avoid intubating the trachea because of the fear of dislodging the mass into the trachea. We did not have facility for jet ventilation in our theatre suite. Also, we did not have the BIS monitor to monitor the level of his consciousness. Nasopharyngeal airway was kept ready for oxygenation, if required. This technique of TIVA and spontaneous respiration are described in children.1,2 Anaesthetist has to closely watch for apnoea, lighter planes of anaesthesia and laryngospasm while using this technique.

REFERENCES