Clarification — “Pretreatment” in RSI

To the Editor: In the July issue of CJEM, Drs. Zed, Harrison and Kuzak expressed disappointment with our opinion that pre-treatment for rapid sequence intubation (RSI) is contraindicated. We would like to clarify that our correspondence regarding this practice in no way implied that pretreatment for RSI is contraindicated. The use of this term misrepresents material taught in our course. Our point is that, although pretreatment may have benefit in certain circumstances, these remain poorly defined and the risk:benefit ratio of this therapy remains unproven. Pretreatment for RSI should not be allowed to complicate or delay timely airway management. Although it is not “contraindicated,” it should not be used as an indicator of “quality of care.”

Sam Campbell, MB BCh
Department of Emergency Medicine
George Kovacs, MD, PHPE
Department of Emergency Medicine
Kirk MacQuarrie, MD
Department of Anesthesiology
And the AIME Instructors
Dalhousie University
Halifax, NS

References
3. Grant: Should Kuzak et al’s original article be cited along with ref 2? (i.e., pages 80 to 84 of the March issue).

AMI after epinephrine

To the Editor: From the point of view of a seasoned veteran with little academic training but a lot of experience working in the trenches I would like to comment on the case of myocardial infarction after epinephrine that was reported in the July issue of CJEM.

I believe it is quite a stretch to think that anaphylaxis was caused by a medication ingested 24 hours prior. I also disagree with the author that ibuprofen infrequently cause severe allergic reactions. I have intubated a young man who arrived apneic after ingesting 200 mg of ibuprofen.

Despite the discussion in the article, I would not use IV epinephrine in a patient who is walking and talking, with normal vital signs. Furthermore, I don’t believe this patient had a myocardial infarction. I think a young man that exhibited impressive ST changes on his ECG secondary to an MI would have equally impressive changes in his CK and troponin. More likely, this patient had an episode of coronary vasospasm with minor myocardial injury that caused a slight troponin rise. To elucidate this further, I would think it mandatory to send this patient for urgent angiograms. Finally, I would not give someone in the throes of an anaphylactic reaction ASA. And by the way, would you give this person epinephrine for their next allergic reaction?

Glen Maddison, MD
Sarnia, Ont.

Reference