Rapid opiate detoxification under anaesthesia

Sir,

Rapid opiate detoxification under anaesthesia (RODA) has been on our treatment menu for several years (Brewer, 1989, 1997a; Brewer et al, 1998) and I welcomed the case report and editorial in your March issue.

Following intensive and unethical promotion of RODA by the CITA organization (Brewer et al, 1998) there have been understandably dismissive reactions in some quarters. Your own coverage was comparatively balanced but Dr Justins' editorial suggestion that 'RODA should only be used in clinical trials until we possess strong positive evidence of effectiveness and safety' has been overtaken by two recent studies from public hospitals with no obvious axes to grind.

Seoane et al (1997) described a technique analogous to RODA, carried out in an intensive-care setting, although without endotracheal intubation. One patient aspirated but recovered completely. They successfully and humanely detoxified (and started on naltrexone) 300 'difficult' heroin addicts who had failed previous detoxification. A month later, 93% were still opiate-free. Tretter et al (1998) also offered RODA to 88 opiate addicts who had failed withdrawal, or found it very distressing, again with excellent results. There were no serious complications.

It is indisputable that using opiate antagonists in opiate withdrawal greatly shortens the acute withdrawal syndrome, although more subtle symptoms, such as lethargy and insomnia, sometimes persist for months after withdrawal. Do we really need clinical trials to be sure that anaesthesia beats placebo for relieving pain during distressing procedures? We accept anaesthesia in severe dental phobia and cosmetic surgery, and epidurals in obstetrics, even though occasional disasters occur and nobody dies from caries, wrinkles or labour pains. To suggest, as some people do, that opiate addicts do not deserve adequate pain relief is unacceptable.

Dr Justins mentions 'deaths and...life-threatening reactions' but no deaths have occurred during anaesthesia. The only British death occurred in a CITA clinic (now closed) and the verdict was 'misadventure aggravated by inadequate care'. The patient was not being nursed in an intensive care unit (ICU). If he had been, he would probably not have died. Like Cook and Collins, we keep our patients in ICU for 24 hours. Most of them now request a naltrexone implant (inserted during RODA) which prevents relapse for at least the first month (Gooberman et al, 1997). Dr Justins may think that Gossop and Strang (1997) 'elegantly summarized' concerns about safety but I have rebutted them in detail (Brewer, 1997b). Many patients can withdraw from opiates using simpler methods. However, like a good family planning service, a good detoxification service should offer a variety of techniques and the choice should be negotiated rather than imposed. For a significant minority of addicts, withdrawal is very distressing. Conventional programmes have at least a 25% drop-out rate and fear of discomfort deters many well-motivated addicts from even trying to withdraw. RODA is a humane and effective alternative.

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Risk assessment and MRSA

Sir,

Methicillin-resistant *Staphylococcus aureus* (MRSA) is now endemic in both hospital and the community and Dr Barrett presents a pragmatic approach for dealing with this (Vol 59(12), 1998, p. 912). He focuses on the importance of high standards of infection control at all times, rather than attempting to identify all colonized individuals who do not have clinical infection.

Dr Barrett's argument is very much in line with the new national guidelines (Working Party of the British Society of Antimicrobial Chemotherapy, Hospital Infection Society and Infection Control Nurses Association, 1998) which point to the need for a risk assessment, contingent upon clinical circumstances.

Thus, while it is may be important to adopt a 'search and destroy' approach in certain high risk areas (e.g. vascular surgery wards), a pragmatic approach sits more comfortably elsewhere (e.g. elderly care wards). This distinction is crucially important because otherwise there may be a tendency for infection control teams to concentrate on MRSA, taking their eye off the ball with respect to other organisms.

I suggest that it is very important for infection control teams to grasp hold of this risk assessment issue and that the concept is integrated into everyday working practice. In addition, it is particularly important that infection control risk assessment is across all fields of infection control activity and not just MRSA.

The time has come to acknowledge that hospital-acquired infection is inexorably linked with the quality of patient care and is recognized as an important component of clinical governance. This being so, the risk assessment approach which has been discussed here needs to be formally linked into the overall risk management process of trusts and be directly related to clinical effectiveness. If this can be achieved, infection control teams will be able to intelligently argue the case for resources where these are deemed to be required on the basis of properly conducted risk assessments.

While MRSA may have been a useful focus to highlight the tremendous importance of infection control, we must now concentrate on infection control more generally. I suggest that the risk assessment approach is the way forward.

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Fosphenytoin and status epilepticus

Sir,

I have read with interest the article by Wallace et al (Vol 59(5), 1998, p. 379) and congratulate the authors on a comprehensive review of the treatment of epilepsy and the use of anti-epileptic drugs. However, I feel it necessary to point out errors in the recommendations for the administration of fosphenytoin for convulsive status epilepticus.

Although one of the major advantages of fosphenytoin is that it can be administered by the intramuscular route to give reliable and predictable therapeutic levels of phenytoin, the time to peak plasma levels of phenytoin are not to be considered to be quick enough to treat status epilepticus. For status epilepticus, fosphenytoin should be administered by intravenous infusion at a rate not exceeding 150 mg PE/minute (PE = phenytoin sodium equivalents). Intramuscular administration of fosphenytoin, however, in contrast to parenteral phenytoin can be successfully used in non-emergency situations.

Second, to avoid dosing confusion, dosages of fosphenytoin sodium should be stated as phenytoin sodium equivalents or PE where 1 mg PE represents 1.5 mg fosphenytoin sodium. The recommended loading dose for fosphenytoin sodium for status epilepticus is 15 mg PE/kg and not as stated by Wallace et al.

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Anaesthesia for Hurler's syndrome

Sir,

I was interested to read of Dr Walker and Dr Grieg's anaesthetic dilemma (Vol 59(8), 1998, p. 668) of how to anaesthetize a child suffering from mucopolysaccharidosis type 1 (Hurler's syndrome) who was bleeding after tonsillectomy. He successfully used a laryngeal mask to gain control of the airway.

An 11-year-old child weighing about 30 kg started bleeding from the mouth at 4 pm on the day of admission. She presented to a district general hospital and was referred onto a casualty department with maxillofacial facilities. The child suffered from mucopolysaccharidosis 3 (San Fillipo syndrome). She was retarded with behavioural problems both day and night.

On arrival at this hospital at 3 am the next morning, examination revealed a frightened, retarded child, expectorating blood. She was cradled and rocked to and fro by her devoted elder brother. A drip had been set up in the referring hospital, 200 ml of Haemaccel had been given. The pulse was 90, blood pressure 110/85, and the capillary return was less than 5 seconds. There was a gastrostomy button.

The bleeding was continuing and it was obvious that the case could not be delayed until daylight hours. The notes were unavailable. A detailed anaesthetic history was taken from the attending mother. The child had had three orthopaedic operations without reported incident. The dilemma concerned how to successfully anaesthetize this child and specifically manage the airway. I was aware of Dr Walker's successful management. I was also aware of the fabled difficulty of anaesthetizing these children and also of reports in newspapers of deaths in this group during anaesthesia.

The child was taken to the anaesthetic room at 4 am. Electrocardiograph and oximeter were attached. She was induced with oxygen, and sevoflurane 8%. Respiratory depression was noted earlier than with halothane. Blind oral suction was performed. A laryngeal mask was inserted and breathing of an obstructive pattern with tracheal tug was immediately noticed. Furthermore the child could not be ventilated through the mask as there was complete airway obstruction. The laryngeal mask was therefore removed and found to be covered with blood and saliva. The problem remained to get the airway clear. After a few seconds I decided that I should suction the oropharynx under vision even though that might have worsened the laryngospasm.

Fortuitously during this, one of the team observed the larynx and the child was immediately intubated. There was a clear aspiration from the endotracheal tube without trace of blood. The child was paralysed with atracurium and ventilated throughout the procedure. The fissure in the tooth was observed to be bleeding freely. The operation was removal of the fractured tooth, and teeth 7 and 8 were also removed. Intramuscular morphine 0.1 mg/kg was administered.

Comment

I did not find the laryngeal mask helpful in anaesthetizing a child who had active bleeding in the hypopharynx, because in my patient, blood and saliva soiled the larynx and led to laryngospasm — in fact exactly the reverse of Walker's experience. I was fortunate in that San Fillipo syndrome in children are usually intubatable. An 11-year-old with Hurler's or Hunter's syndrome one could confidently expect to be unintubatable by direct laryngoscopy.

I describe this case in contrast to Walker and Greig's management with a laryngeal mask. It underlines the necessity when dealing with difficult airway management in children of having a variety of options available. In neither case, it should be noted, did any anaesthetist even dream of paralysing the obstructed child with this condition.

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Development of echocardiography

Sir,

Heart failure is common and an expensive condition to treat, costing the NHS £360 million each year. With the vast majority of patients being treated by a non-cardiologist, suspected heart failure is the most frequent indication for open access echocardiography. In the editorial on development of open access echocardiography services, De Bono makes the important point that cost-effectiveness data is scarce (Vol 59(8), 1998, p. 600). Many studies have demonstrated the benefit of angiotensin-converting enzyme inhibitors (ACEIs) in patients with left ventricular systolic dysfunction (CONSENSUS Trial Study Group, 1987; SOLVD Investigators, 1991; Acute Infarction Ramipril Efficacy (AIRE) Study Investigators, 1993). Dosage is debated but physicians should aim for the landmark trials target doses (NETWORK Investigators, 1998). ACEIs remain significantly underprescribed in both general and hospital practice. Clearly, it would be extremely unsatisfactory for left ventricular dysfunction to be discovered only for appropriate treatment to be withheld.

We have demonstrated a difference in ACEI prescription between patients referred for open access echocardiography with subsequent primary care, and those followed up by a specialist heart failure clinic. In patients without contraindications to ACEIs the rate of prescription was significantly different (83% primary care, 98.5% heart failure clinic, $P<0.05$); patients treated in the specialist clinic were also more than twice as likely to have achieved major trial target doses. Patients not on treatment were more likely to have received a previous trial of an ACEI in the heart failure clinic.

With the high mortality, morbidity and cost of heart failure it is imperative that patient management is optimized. Open access echocardiography without specialist referral may lead to sub-optimal treatment; this must be considered when evaluating the usefulness of the service.

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