We go to great lengths to specify electromedical and program features when compiling specifications for equipment, but how often do we specify what we expect of the wheels that carry the equipment? Wheels that turn easily on all surfaces, large enough to ride over electrical cords and other speed bumps, and not fall into the gaps between floor and lift doors.

Until we start specifying size, weight load, construction type e.g., ball race with sealed lubricant or grease nipple for regular lubrication, we will continue to have our critical and expensive equipment moved on shonky wheels. We also need to have fitters regularly inspect, service and replace wheels and this cost needs to be factored in.

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Availability of parenteral quinine

The Palmerston North Hospital Intensive Care Unit has a large military base in close proximity. Troops from that base have formed a large component of the New Zealand military presence in East Timor. Unlike the Darwin ICU[1], we have not yet had to deal with any cases of severe malaria. Upwards of 75 cases of lesser degrees of malaria (predominantly vivax) have been successfully managed at the military base Medical Treatment Centre, with only a handful of cases requiring admission to this hospital. Given our proximity to the base, following troop deployment to Timor, a strategy for dealing with severe falciparum malaria was developed in anticipation of cases such those that have been reported from Darwin[1]. As part of that development, we discovered that parenteral quinine is unavailable in New Zealand. The New Zealand Defence Force does not carry any stock, rather relying on the supplies of the Australian Defence Force. The latter is not able to on-sell any quinine. We have experienced significant delays in securing supplies of quinine for injection, compromising our ability to have managed any cases of severe malaria. In New Zealand, artemisinin derivatives are also not readily available. I believe that general availability of parenteral quinine and artemisinin derivatives is equally limited in Australia. As well as having identified a source of intravenous quinine, we have also been able to secure supplies of parenteral doxycycline which may be of use in treating quinine resistant falciparum malaria[2]. Both drugs have been sourced for us by Baxter Healthcare, Auckland, N.Z. Their suppliers have been Martindale Pharmaceuticals Ltd, Romford, U.K. (quinine), and American Pharmaceutical Partners Inc, Los Angeles, U.S.A. (doxycycline). This letter serves to advise others of the quinine availability problem. Some advance planning may be required in units where there is a higher likelihood that severe malaria will be encountered, and where military supplies of quinine are inaccessible.

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Unexpected difficulty administering an epidural top-up for caesarean section

We report an incident involving an 18 gauge Portex epidural catheter (Portex Limited, Kent, U.K.).

An obese 24-year-old primigravida, weighing more than 130 kg, had an 18 gauge lumbar epidural catheter inserted and a block established for labour analgesia. The catheter was taped to her back and over her left shoulder with a Hypafix (Smith & Nephew, France) dressing. Analgesia was satisfactory with hourly bolus top-ups of 10 to 15 ml of ropivacaine 2 mg/ml and fentanyl 2 μg/ml solution. Four hours later the obstetric team made the decision to proceed to an urgent caesarean section as the patient was failing to progress in labour and there was fetal acidosis and some other features of fetal distress. We attempted to administer an epidural top-up solution of 2% lignocaine with adrenaline 1:200,000 via the bacterial filter using a 20 ml syringe in order to establish a block adequate for caesarean section. This proved impossible as a high resistance to injection was encountered. Close inspection of the epidural catheter revealed that the proximal (filter) end of the catheter was stretched lengthwise and the lumen narrowed for 20 cm from the catheter filter screw cap

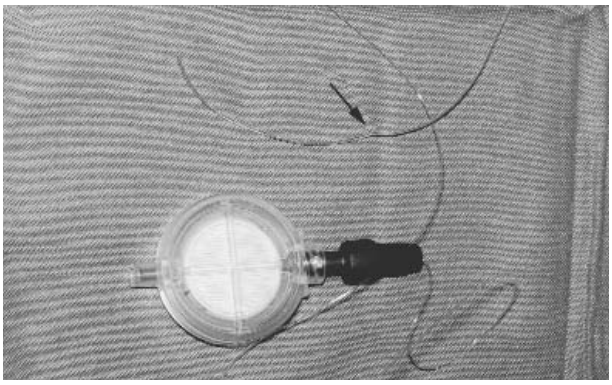

FIGURE 1a: The epidural catheter at the proximal (filter) end has been stretched length-wise and the lumen narrowed for 20 cm from the catheter filter screw cap. Arrow indicates junction of narrowed and normal calibre catheter.

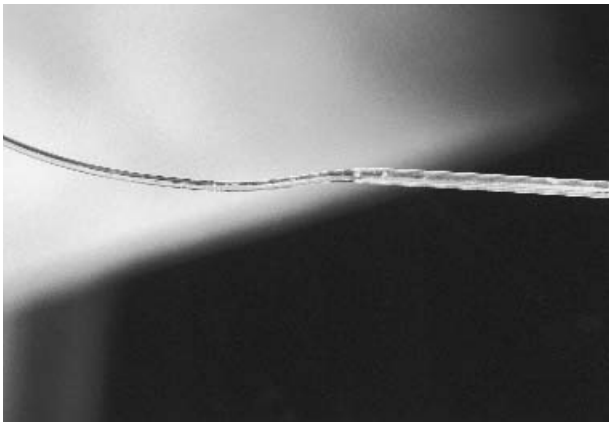

FIGURE 1b: Close up view of the junction between narrowed section and normal calibre epidural catheter.

(Figure 1a). Distally where the epidural catheter was more firmly affixed to the patient's back with Hypafix, the catheter appeared to be of normal calibre (Figure 1b).

We proceeded to soak the most proximal 10 cm portion of apparently normal calibre epidural catheter with 0.015% chlorhexidine and 0.15% cetrimide aqueous antiseptic solution (Baxter Healthcare, N.S.W.). This section of the epidural catheter was approximately 25 cm from where the catheter penetrated the patient's skin. After two minutes soaking we dried the catheter with sterile gauze and then cut it with a pair of sterile scissors. We then reconnected the cut distal end to a new sterile epidural screw cap and bacterial filter. No further resistance to injection was encountered and the patient developed a satisfactory block to T4 dermatome within ten minutes, which allowed caesarean section to proceed without further delay.

It seems likely that patient movement prior during transfer to the operating theatre suite resulted in a section of epidural catheter being stretched to a point where attempts to administer epidural medications became impossible. Fortunately in this case an epidural bolus top-up was accomplished in a morbidly obese patient who could otherwise have been placed at increased risk if the caesarean section had to be performed under general anaesthesia. Our routine postoperative analgesia regimen includes preservative-free epidural pethidine 25 to 50 mg bolus top-ups for 24 to 48 hours. In this case the epidural catheter continued to function satisfactorily and was removed within 24 hours postoperatively to reduce any additional risk of infection.

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Problems with the rubber stopper of a propofol ampoule

I have used a blunt needle to draw up drugs from ampoules with rubber stoppers, e.g., antibiotics, muscle relaxants etc., for a number of years. I believed that the rubber core produced by the blunt needle could not be drawn up into the syringe. But I was wrong!

Recently, at the Royal Women's Hospital, the supplier of propofol changed. The new ampoule has a rubber stopper. Using an 18 gauge blunt drawing up needle (Becton Dickinson) I managed, with the minimum of effort, to create a rubber core and draw it into the syringe (Figure 1). The core could have

FIGURE 1