antiemetics' adverse events introduced recently by several investigators?

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Nonpharmacologic Sedation in a Deaf Child

To the Editor:

A 3-yr-old child was referred to our institution for a magnetic resonance imaging (MRI) examination of the ears. He had a partial deafness. Previously, he underwent an unilateral cochlear implant, which had failed. The MRI examination was performed to find the cause of the failure.

When asked about fasting hours, his father admitted that the child had eaten 30 min before the time set for the examination. Because of a very busy schedule, it was not possible to postpone his examination. It was decided after consulting with his father to try to put him to sleep "naturally." His father took him in his arms and, indeed, he fell asleep. We were able to proceed with the MRI scan for 45 min uneventfully. It was a good alternative because in this particular case, we did not need to inject gadolinium contrast (so no need for an IV line). In addition, because of his deafness, the noise of the MRI machine did not wake the child, and he remained motionless.

For ambulatory pediatric sedation, a natural sleep is, in certain conditions, an alternative that should be kept in mind.

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Fiberoptic Endotracheal Intubation Through an Ultra-Thin Bronchoscope with Suction Channel in a Newborn with Difficult Airway

To the Editor:

Management of the airway may be difficult in newborns with craniofacial and neck malformations (1). Previous experiences with flexible endoscopic intubation in neonates have shown encouraging results, but a number of limitations, such as no directional control at the tip or lack of an operative channel, were also reported (2,3). We describe a successful intubation by a new 2.5-mm fiberoptic bronchoscope with a 1.2-mm suction channel in a newborn with difficult airway.

A 2300-g infant, born at 35 wk of gestation after an urgent cesarean delivery for fetal distress, needed cardiopulmonary resuscitation at birth. Endotracheal intubation was achieved only after several attempts with a 3.0-mm tube inserted nasotracheally. On arrival to our unit, physical examination showed dysmorphic face, micrognathia, and arthrogryposis. A gross air leak around the endotracheal tube (ETT) prevented an adequate ventilation of the patient. We decided to explore the patient's larynx before exchanging the ETT with a larger one, but micrognathia did not allow proper visualization by conventional laryngoscopy. Thus, we inserted a 3.5-mm ETT using a fiberoptic flexible bronchoscope (Richard Wolf-GmbH, Knittlingen, Germany). This endoscope has a 2.5-mm outer diameter, a 1.2-mm instrument channel, an angle of deflection at the tip of 160° up and 130° down, and a working length of 450 mm (Figure 1). During the procedure, we could remove secretions and provide topical anesthesia via the suction channel of the endoscope. No complications were noted.

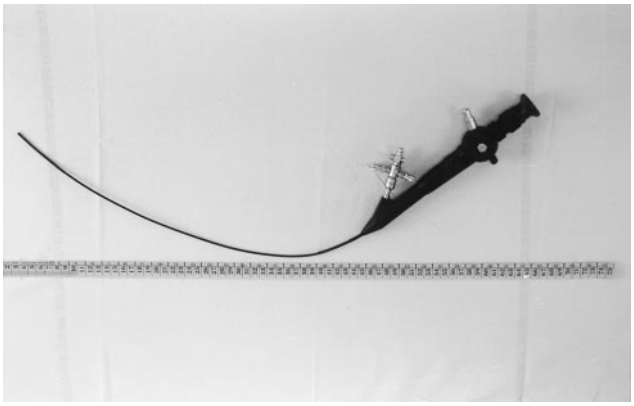

Figure 1. Fiberoptic flexible bronchoscope.

We believe this new ultra-thin bronchoscope may be useful in newborns and small infants when a difficult intubation is anticipated or, alternatively, when lower airway evaluation, suctioning, bronchoalveolar lavage, or supplemental oxygen delivery during intubation is required.

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Which Intravenous Sodium Channel Blocker for Neuropathic Pain?

To the Editor:

McCleane's (1) comparison of IV phenytoin with placebo to relieve neuropathic pain is of interest in an area in which the only two previously controlled trials with oral phenytoin produced conflicting results (2,3).

However, McCleane's study statistically analyzes mean pain scores rather than determining from individual patient scores clinical significance, i.e., >50% pain relief and >75% relief. The decrease in overall pain score (0–10 linear visual analog score) in the phenytoin group from a mean (±SD) of 4.62 (±3.46) to 3.25 (±2.95) does not quantify the "significant benefit" judged by 8 of 20 patients, making comparison with other analgesics difficult. Furthermore, although both groups included the same patients, the mean overall pain score in the placebo group preinfusion was much higher 7.18 (±1.47) than the phenytoin group 4.62 (±3.46), suggesting a significant change in pain severity during the week between infusions, which would affect outcome.