
Thirty-five Franklin Size Double Lumen Tube May Not Be Suitable for Tall Patients

To the Editor:
A recent study by Amar et al. concluded that the use of smaller than conventionally sized double lumen tubes (DLTs) was not associated with any differences in clinical intraoperative outcomes including transient hypoxemia. However, the authors used DLTs from one manufacturer (Sheridan, Teleflex Medical, Research Triangle Park, NC).1 Partridge et al. have shown that same size DLTs from different manufacturers have different margins of safety with tubes manufactured by Sheridan having a greater margin of safety compared to those from other manufacturers.

Thus, we suggest that extrapolating these results to DLTs other than those manufactured by Sheridan may result in more episodes of intraoperative tube malposition and hypoxemia. Although the ready availability of fiberoptic bronchoscope to adjust for DLT displacement or malposition during surgery is considered routine care, too frequent adjustments by the fiberoptic bronchoscope intraoperatively could be both cumbersome and may not be possible in all cases.

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1. Partridge L, Russell WJ. The margin of safety of a left double-lumen tracheobronchial tube depends on the length of the bronchial cuff and tip. Anaesthesia Intensive Care 2006;34:618–20

Intraarticular Tramadol or “Hot Chili Peppers”?

To the Editor:
Fans of tramadol should thank Zeidan et al. for their recent report,1 showing that tramadol 100 mg, used as an adjuvant to bupivacaine and injected intraarticularly, provides extended analgesia after arthroscopic knee surgery. Our concern is, however, the safety of tramadol administration into the knee joint. It has been found that tramadol can lead to local release of various peptides that act on neighboring tissues, producing vasodilation, immunomodulation, cytokine and mediator release.2 These effects have been attributed to activation of the transient receptor potential vanilloid-1 (“the capsaicin receptor”), which can also be activated by hot chili peppers2 and is supported by human studies, showing that local tamadol, can result in skin erythema, flare, and urticaria, and initiate burning skin sensation.3,4 It is conceivable, therefore, that if tramadol, applied locally, can cause such on-site responses, then it may also produce similar effects in the knee, which leads us to question the safety of intraarticular tramadol injection.

In our opinion, tramadol, resembling “hot chili peppers” in action, should be proven devoid of untoward effects on the knee, before the practice of intraarticular tramadol is considered safe.

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In Response:
Although we agree that the paper by Partridge and Russell1 points to inter- and intramanufacturer variability of double lumen tubes (DLT) cuff to tip distances, they also did not provide any statistical comparisons between the sizes among the manufacturers to substantiate that smaller DLT by Sheridan are safer. Thus, and as pointed out by Punj et al.2 our conclusions were based on use of DLT from a single manufacturer. In addition, and as stated in our paper, we view fiberoptic confirmation and intermittent verification of DLT position regardless of manufacturer as an integral part of the anesthetic management.

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2. Partridge L, Russell WJ. The margin of safety of a left double lumen tracheobronchial tube depends on the length of the bronchial cuff and tip. Anaesthesia Intensive Care 2006;34:618–20

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A recent study from Marincsak et al. 2

In the clinical setting, tramadol can be used intramuscularly and local application of tramadol has been described, many years of investigation could be done safely and its correlation with and extrapolation to overall safety. Our study focused on side effects and our data showed no side effects of intra-articular (IA) tramadol 100 mg during the first 24 hr postoperatively. 3 We are convinced that our investigation could be done safely as several studies showed that IA tramadol can be used safely during arthroscopic surgery. 4 –6 Additionally, Garlicki et al. 7 showed that tramadol inhibits nociception and edema after its local application directly to the inflamed knee joint, which is in contrast with the reports mentioned by Dr. Tabboush. Finally, although effects of local application of tramadol have been described, many years of clinical use suggest that tramadol can be used intramuscularly and subcutaneously without significant major side effects. However, because IA administration of tramadol still has to be considered an experimental application, we agree that more research is required to prove and support the safety of its IA administration.

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In Response:

We agree with Dr. Tabboush that the mentioned side effects are well known. 1 We also are aware of the recent study from Marincsak et al. 2 and acknowledge this work for offering a better understanding of the side effects and/or mechanism of action of tramadol. However, we believe that one should differentiate between the onset of side effects and its correlation with and extrapolation to overall safety. Our study focused on side effects and our data showed no side effects of intra-articular (IA) tramadol 100 mg during the first 24 hr postoperatively. 3 We are convinced that our investigation could be done safely as several studies showed that IA tramadol can be used safely during arthroscopic surgery. 4 –6 Additionally, Garlicki et al. 7 showed that tramadol inhibits nociception and edema after its local application directly to the inflamed knee joint, which is in contrast with the reports mentioned by Dr. Tabboush. Finally, although effects of local application of tramadol have been described, many years of clinical use suggest that tramadol can be used intramuscularly and subcutaneously without significant major side effects. However, because IA administration of tramadol still has to be considered an experimental application, we agree that more research is required to prove and support the safety of its IA administration.

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Coagulation Monitoring

To the Editor:

Viscoelastic coagulation tests are used to manage perioperative coagulation disorders, and we believe that a recent article by Ganten and Hofer 1 contains a misleading legend probably reflecting a misunderstanding of the concept of the Sonoclot device. In Figure 3B explaining the Sonoclot device, platelet function (PF) was defined as the time from beginning of the Sonoclot measurement until the peak of the curve. However, the function of the platelets is reflected by both the rate of clot formation (steepness of the curve) as well as the retraction of the clot, represented by the following Sonoclot signature after the peak. 2 The downward slope after the peak is produced as platelets further contract the clot. Both the number of available platelets and the level of PF are key determinants of the downward slope. The peak itself is a composite measurement of the fibrinogen and the interaction of platelets with the coagulatory cascade. Finally, also included in the PF time is activated clotting time. This value is obviously influenced by heparin, but not by platelets.

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In Response:

Casutt and Schüpper 1 commented on the concept of the platelet function (PF) measured by the Sonoclot Analyzer (Sonoclot Coagulation & Platelet Function Analyzer, Sienco, Arvada, CO). Figure 3B in our article 2 presented an initial characterization of the Sonoclot Signature and attempted to illustrate that there is both a time component related to platelet activation as well as a clot retraction quality component. Although the graph only introduced the concept of PF, the text clearly states that PF as reported on the Sonoclot Analyzer is “derived from the timing and quality of the clot retraction.” The actual algorithm for the numerical PF result

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2093