In Response:

We agree with Meyer et al.1 that true seizures with propofol are rare, but not zero; the most risky periods for both true seizures and abnormal nonseizure movements are during the recovery or induction phases of anesthesia, and that propofol has predominantly depressive effects on the cortex.

However, we also maintain that seizures with thiopental are probably even more rare than those after propofol (although in the absence of an accurate denominator this could be disputed) and that induction of cortical depression is often associated with paradoxical cortical hyperexcitability. Meyer et al. seem to agree with this, as their sentence: “It is also important to note that pro- and anticonvulsant mechanisms are modulated by the given dose of propofol as inhibitory central nervous system structures are more sensitive to depression than excitatory ones” would support a proepileptogenic mechanism of propofol. In our article, we termed this mechanism “inhibiting-the-inhibitors.” 2

We would therefore suggest that the correct title of this letter should be: “Propofol: Pro- and Anticonvulsant Drug.”

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REFERENCES


Intrathecal Morphine Pump Malfunction Due to Leakage at the Catheter Connection Site: A Rare Problem and Its Prevention

To the Editor:

Implanted intrathecal drug delivery systems provide excellent pain relief and reduced drug toxicity in patients with refractory cancer pain.1,2 Common complications include postpuncture headache (15%), external leakage of cerebrospinal fluid (3.5%), CSF hygroma (1.5%), catheter tip dislodgement (1.5%) and catheter system leakage (1.5%). Infection of implanted systems are a rare occurrence, mostly in the first 3 mo after implantation.3

We report a pump malfunction resulting from pump-catheter connection failure and a strategy to avoid this complication. A 72-yr-old patient with bladder cancer metastatic to the sacrum and lumbar plexus was receiving the equivalent of 750 mg morphine per day postoperatively, but with significant sedation and still inadequate pain control. A percutaneous intrathecal catheter was placed and an infusion of morphine begun. The patient improved rapidly, showing much lower pain scores while being alert and mobile.

Subsequently, an intrathecal drug delivery pump (Medtronic Synchromed II 8637) was implanted. An epidural fibrin glue patch was performed at the catheter entry site to the dura to minimize the risk of cerebrospinal fluid leakage along the catheter.4 In the first postoperative days, the daily morphine dose had to be increased rapidly without improvement of the pain scores. At the same time, swelling and fluctuance over the pump pocket was noted. The pump pocket was punctured and blood-tinged fluid aspirated. The catheter side port of the pump was accessed under fluoroscopy and, upon injection of contrast medium, a leak was identified at the pump-catheter connection site (Fig. 1). Upon surgical revision, the catheter connector was in place but could be disconnected easily. The snap connector extension was replaced and the new piece reattached to the pump with considerable extra force. The connection was then manually tested for leak using a saline injection in the catheter access port while occluding the catheter distally, a procedure we now routinely use for all pump implantations. Laboratory examination of the aspirated fluid showed no bacterial growth and was positive for β transferrin, confirming a retrograde cerebrospinal fluid leakage to the pump pocket. According to an oral communication from the Medtronic...
Company, there have been three similar reports of malfunction of the snap connector.

We recommend testing the pump-catheter connection at implantation by injecting a small amount of normal saline under pressure through the side port of the pump while occluding the distal catheter manually and applying fibrin glue epidurally around the spinal needle dural puncture site.3,5

REFERENCES

1. Smith TJ, Coyne PJ. Implantable drug delivery systems (IDDs) after failure of comprehensive medical management (CMM) can palliate symptoms in the most refractory cancer pain patients. J Palliat Med 2005;8:736–42

In Response:

Worner et al.’s report is likely an example of imperfect connection of the catheter to the pump at implant. Such occurrences can cause either catheter disconnection or occlusion and we are grateful to the authors for pointing out a related adverse event, collection of CSF in the pump pocket. Disconnection and occlusion, with or without CSF collection in the pocket, can result in patient symptoms, including lack of therapeutic effect, clinically significant or fatal drug-under dose (e.g., intrathecal baclofen withdrawal), or a return of underlying symptoms or drug withdrawal symptoms.

In 2008, Medtronic became aware of the potential for disconnection or occlusion associated with the sutureless connector because of misalignment or incomplete connection of the connector to the catheter port. The sutureless connector can be used for catheter Model Numbers 8709SC, 8731SC, 8596SC, and 8578, with Medtronic SynchroMed® and Isomed® implantable infusion pumps. It is not used with Medtronic MiniMed insulin pumps. Medtronic issued a Medical Device Safety Alert in June 2008 to address the proper connection of sutureless connectors on intrathecal catheters, http://www.medtronic.com/disclosure/product-advisories.html.

We refer physicians who implant and manage intrathecal infusion pumps to this communication as it contains illustrations and instructions that should clarify how to accurately align the sutureless connector to the catheter port. Proper alignment of the sutureless connector should mitigate the potential for sutureless connector disconnection, occlusion, or CSF collection in the pump pocket.

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REFERENCE


Ultrasonographic-Assisted Ganglion Impar Neurolysis

To the Editor:

We applaud the description by Gupta et al.1 of ultrasound-assisted block of the ganglion impar. However, because others may wish to perform this block, additional information, including description of the probe and the angle of insonation, should be included. Also, because some subjects will have a substantial concavity of the sacrum-coccyx, which will make accessing the ganglion using a straight needle difficult, regardless of the ancillary imaging technique, the shape and length of the needle and the type of contrast should be provided.

I am especially pleased that, almost two decades after our original description with a specific technique, the gate remains open and others have endeavored to improve it. Finally, what is most important is that this tiny structure has been acknowledged as having a pivotal role in pain of sympathetic origin in the perineal pelvic region. Before that description, no clinician had suggested it as a target for the management of severe perineal pain.3

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In Response:

It is encouraging to receive appreciation from Dr. Plancarte, the