Coincidence, conscious sedation, CAEP and ketamine

To the editor:

As I write this letter, I'm about to write a cheque and once again renew my membership to this august national organization, the Canadian Association of Emergency Physicians (CAEP). Each year I ask if this is really necessary, and each year I write the cheque anyway. This year I have something new to contemplate.

About 8 years ago, our ED introduced ketamine for procedural sedation. Predictably, we were met with protests from the anesthetists, which we ignored. We were glad when the matter was referred to our Medical Advisory Committee (MAC) and ecstatic when the MAC appointed sympathetic people to review the issue. We were prepared with arguments for efficacy and patient safety, but not for what the anesthetists actually threw at us. They argued that there was no legal context in Canada for us to use a drug reserved, up to that time, to general anesthesia. Furthermore, they suggested that if the hospital were ever sued, there would be no legal defence for allowing us to use it. They were correct, and our sympathetic panel apologized one by one, then voted to support the anesthesia motion. That ended our experiment for 8 long years.

When the CAEP sedation guidelines were published in early 1999,[1] I sensed that the landscape had suddenly changed. With national standards published and supported by our specialty society, the legal position of our department and of the hospital changed overnight. We reinstituted the use of ketamine and, predictably, the anesthetists challenged us again. Once more, the matter was referred to the MAC, and then to another subcommittee. This time we had the published guidelines as evidence, along with a list of Canadian hospitals using ketamine and propofol. This time the decision went in our favour. Within a few days, Anesthesia withdrew their objections and indicated they would no longer interfere with our department's internal policies.

It occurs to me that during those two years of struggle, when CAEP was negotiating with the Canadian Anaesthetists' Society and the guidelines were being born, there may have been times when the participants wondered if it was all worth it, and whether they would really make a difference. I want to tell you that Yes, it was, and Yes, it has. This year I have no doubt at all about the reasons for signing another cheque for my CAEP membership.

On behalf of all my colleagues, thanks to all the members who worked on the sedation guidelines project.

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Reference

1. Innes G, Murphy M, Nijssen-Jordan C, Ducharme J, Drummond A. Procedural sedation and analgesia in the emergency department. Canadian Consensus Guidelines. J Emerg Med 1999;17:145-56.

Esophageal detector devices

To the editor:

I was pleased to read *CJEM*'s recent Journal Club article[1] comparing esophageal detector devices (EDD) and end-tidal CO_2 monitoring ($ETCO_2$). I agree that EDD is cheap, easy to use, portable and superior to $ETCO_2$ in arrest situations, but would like to caution that there are clinical factors that may give rise to false-negative EDD results.

We studied the EDD in 300 patients and found 2 cases where it falsely suggested esophageal tube placement. One of these patients was obese and the other had bronchospasm, causing the EDD to reinflate very slowly despite appropriate position in the airway.

Despite the availability of $ETCO_2$ monitoring in our operating room, I continue to use EDD and teach the residents about its usefulness. Although most emergency rooms use colorimetric or waveform (CO_2) technology, I believe that EDD has an important role in the detection of endotracheal tube position and I commend Drs. Rhine and Morrow for their review of this topic.

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Reference

1. Rhine DJ, Morrow DJ. Is the esophageal detector device or end-tidal CO_2 measurement superior in confirming endotracheal tube placement? CJEM 1999;1:103-4.

The audience is widening

To the editor:

Our local cardiologist found the first 2 issues of *CJEM* while he was doing a clinic in a rural hospital. He twice made a point of telling me enthusiastically how much he has enjoyed the journal, and how valuable he feels it is going to be as an education instrument. He was particularly interested in the cardiology series and said he learned a number of practical things while reading it. Hopefully our hospital library will carry *CJEM*. Congratulations on a job well done.

Jim Thompson, MD
Charlottetown, PEI

To the editor:

On behalf of the Medical Library, I'd like to thank you for the first issues of *CJEM*. We look forward to receiving more issues for some time to come!

Helga Patrikios
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