Letters

To the Editor:

In response to the recently published article, "The dual role – Educator and lobbyist" (AANA Journal, 1991;59:106-108) authored by Tom McKibban, CRNA, MS, I feel I must take exception to some of his comments.

Pennsylvania has more CRNAs and more schools than any other state. If one was to examine the composition of our Board, it would be shown that educators have played a very active role in issues regarding government relations, practice rights and education. During this last decade, Pennsylvania has had five educators who served as State Presidents and to date, there are no less than four additional program directors serving on our Board. Educators and program directors in other states have accomplished the same. Also, in looking at the composition of past AANA Boards, program directors and educators have gone through the ranks right up to the Presidency of our association.

I feel that educators, including myself, have not been neglecting their responsibilities nor have we been relying on the practitioners to advocate issues involving student education, or issues involving practice rights or reimbursement. My files are overflowing with letters I’ve written to my state and federal representatives addressing these very things. Moreover, the Government Relations Workshop, held in May 1991, was the fourth time I have attended this event. Most of my colleagues have been equally active.

I’m sure Mr. McKibban’s comments were well intended but misguided. Until recently, educational issues have been placed on the back burner. All CRNAs should be concerned about educational issues: school closures, funding for program and faculty development, student traineeships, clinical access and equitable treatment of students in regard to supervision/reimbursement ratios. I believe Sandy Maree, CRNA, MEd, AANA past-president, put it quite succinctly a few years ago when she said, “If a profession isn’t growing, then it must be dying.”

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Response:

I am pleased that Ms. Wildgust took an aggressive and informative defense of her participation as an active professional who is obviously deeply involved in the legislative arena. As with any observation, there are exceptions to the rule, and she obviously represents one of the most articulate.

My purpose in writing the article was to reinforce the positive aspects of collective lobbying efforts between practitioners and educators since together they provide a much broader and more representative perspective on the issues at hand. I was also very pleased to see the large attendance of CRNA educators this year at the half-day workshop in conjunction with the Government Relations Workshop, which was designed specifically to acquaint CRNAs on the “facts and fiction” of lobbying and the important educational issues to which we are all dedicated to resolve.

TOM L. MCKIBBAN, CRNA, MS
Eldorado, Kansas

To the Editor:

I was interested in the article, “Reducing the need for intubation in plastic surgery,” (AANA Journal, 1991;59:131-135), authored by Lyle E. Gates, CRNA, BSN; Edward Hamacher, MD, JD; and Dan Simonson, CRNA, BSN.

An important part of this article was the use of what is now called “tumescent technique” local anesthesia. However, cautious evaluation needs to be given to the lidocaine concentration (0.25%) used by the authors. Further, the pioneering work of Drs. Klein and Lillis should certainly be listed in the references for such an article.1,6 Both Klein and Lillis have been instrumental through their teachings at seminars, workshops, and national meetings, as well as through their writings, in making the tumescent technique of local anesthesia familiar to all the specialties now doing liposuction and other forms of cosmetic surgery, a technique which has now spread all around the world. Dr. Klein is probably the current world expert on local anesthesia.

Klein and Lillis have shown that buffered .05-0.1% lidocaine with 1:1 million epinephrine is adequate even for unsedated or very mildly sedated procedures including extensive liposuction. Both have found it safe to use 35 mg/kg of lidocaine if the concentration is quite dilute (i.e., 0.1% or less), and both feel that up to 50 mg/kg is probably safe also. The patient must be healthy and have good liver function. Dr. Klein has found that absorption of lidocaine from subcutaneous fat is inversely proportional to the concentration of the solution, and that the peak concentration for dilute solution (0.05-0.1%) occurs at about 12-16 hours postoperatively.

I am concerned because the article did not describe the length of time over which the sometimes large quantities of 0.25% lidocaine were injected (important as stronger concentrations are approached), and in only one case of high volume use was the lidocaine level measured at 17 hours. In that one case, the figures given would suggest that the lidocaine peaked at 2 hours with the 0.25% solution. In two of the five patients listed, very large concentrations of lidocaine were used, namely 63 and 74 mg/kg respectively. One patient reached toxic levels.

Even for breast augmentation, with the stretching and nerve stimulation associated with pocket creation, approximately 250 cc for each side of 0.1% lidocaine with 1:1 million epinephrine is adequate in conjunction with moderate intravenous sedation. Most of the other procedures mentioned by the authors will also respond to this concentration of lidocaine in the volumes listed, except that liposuction of multiple areas will usually require significant volumes of dilute solution, larger volumes than those shown by the authors, but with approximately the same total milligrams of lidocaine being used. It would appear that the volume of the local anesthetic solution is just as important as the concentration, if not more so, in achieving adequate anesthesia. For these procedures, it is not necessary to use heavier sedation such as ketamine, and, in fact, Dr. Klein uses almost no sedation at all. Personally, I have found it helpful to use an anesthetist and moderate sedation with meperidine, midazolam, and adjunctive droperidol.

Once again, I would call the authors’ and your readers’ attention to the very important work of Drs. Klein and Lillis, which has literally revolutionized the use of local anesthesia with cosmetic and plastic surgery in just 5 short years.

REFERENCES


BRUCE B. CHRISMAN, MD, FIACS
Cosmetic Surgery Hawaii
Honolulu, Hawaii
Response:

We wish to thank Dr. Chrisman for his informative and well-researched letter concerning our article, "Reducing the need for intubation in plastic surgery." Dr. Chrisman's letter supports our contention that large volumes of dilute local anesthetic and vasoconstrictive medications administered by bullet-tipped needles can be safely used to anesthetize patients for plastic surgery procedures.

He also supports our contention that when using this technique, one may safely exceed the recommended mg/kg dosage as listed in the package insert for lidocaine. We share his concern about the high blood levels sometimes associated with our technique, and we appreciate his assertion that one may use even more dilute solutions of lidocaine with equal effect. We believe that the lowest concentration of lidocaine which will achieve adequate anesthesia is the safest.

The references to the work of Drs. Klein and Lillis are very helpful, and we are chagrined that they escaped us during our review of the literature. We recommend the references highly to the reader.

Dr. Chrisman does not take issue with our technique of intravenous sedation using subanesthetic doses of ketamine, and he agrees with us that some type of sedation, as well as the presence of an anesthetist, is appropriate in these cases.

In summary, we feel that Dr. Chrisman offers some important cautions and comments to the reader concerning our technique, and we recommend experimentation with his approach (and that of Drs. Klein and Lillis). We will certainly try it in our own practice.

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