ing $0.83 in the Schwarz paper). There is no doubt that isoflurane is cheaper to use in this context, but the savings resulting from the use of a closed circuit are equally impressive. In this era of routine monitoring of the expired gases, there is no justification for the maintenance of anesthesia with flows as high as 1 L·min⁻¹.

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Reference

REPLY:
We thank Dr. Harris for his interest in our trial and are grateful for the opportunity to reply. We agree that low-flow anesthesia utilizing modern closed-circuit anesthesia delivery systems is associated with decreased volatile agent consumption, and, hence, decreased volatile agent cost, compared to higher flows. This topic has been subject of review in the literature,¹,² and was discussed in our publication.³ However, our trial was neither intended nor designed to study the pharmacoeconomics of ultralow-flow anesthesia. Nevertheless, isoflurane is significantly less expensive than desflurane, even under ultra-low-flow conditions;⁴ Dr. Harris’ conclusions are in agreement with these findings. Regarding Dr. Harris’ statement that “there is no justification for the maintenance of anesthesia with flows as high as 1 L·min⁻¹”, a reduction from 1 L·min⁻¹ to 0.5 L·min⁻¹ of fresh gas flow produces no significant reduction in isoflurane consumption.⁴ As we have insufficient information available on the experimental design, methods, and actual flow rates used by Dr. Harris, we are unable to make more detailed comments on his results. We look forward to his publication on this important matter.

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References

Absence of pulse and blood pressure following vasopressin injection for myomectomy

To the Editor:
Complications from vasopressin injection into the uterine wall to limit blood loss during myomectomies¹ appear to be rare. We found one report of pulmonary edema and cardiac arrhythmias after vasopressin injection.² We present the case of a healthy 31-yr-old woman who received a combined spinal epidural with 5 mg of bupivacaine, 25 µg of sufentanyl, and 0.25 mg of preservative-free morphine intrathecally. General anesthesia was induced with 2 mg·kg⁻¹ propofol iv and maintained with 0.6 MAC desflurane. The blood pressure (BP) decreased to 80/45 mmHg post induction. Heart rate (HR) was 67 beats·min⁻¹. Phenylephrine, 0.1 mg iv, easily corrected the BP and four additional doses were needed before vasopressin injection. There was no hemodynamic response with skin incision. After exteriorization of the uterus and verification that the needle was not intravascular, 3 U of a 0.5 U·mL⁻¹ solution of vasopressin were injected into the uterine wall. The next BP cycle did not register a value, HR was 45 beats·min⁻¹ and 5 mg of ephedrine were given twice for presumed hypotension. The pulse oximeter became flat. The ECG showed normal sinus rhythm. Bilateral radial pulses were absent, but a faint carotid pulse was palpable. The skin colour did not change and the mucus membranes were pink. The electrocardiogram (ECG) changed to an atrioventricular block with bigemmini at 45 beats·min⁻¹. There was no change in the end-tidal CO₂. The surgeon communicated that the bleeding was brisk. We assumed the cause to be intravascular vasopressin, and decided to continue the surgery while giving 50 mg of propofol iv and increasing desflurane to 2 MAC. The pulse oximeter reappeared five minutes later at 100% saturation with a BP of 198/95 mmHg at 60 beats·min⁻¹. The BP normalized after 15 min of addi-