A Canadian history lesson

A recent news item about Canada's support of a UN resolution on nuclear disarmament[1] included a photo depicting a woman protesting nuclear testing in 1961. It was unfortunate that the caption did not identify the woman as Senator Thérèse Casgrain, daughter of Lady Blanche MacDonald and Sir Rodolphe Forget. Senator Casgrain was well known not only for her social democratic ideas, but also for her defence of women's rights. It was because of her and her associates that women were finally given the right to vote in Quebec. She was an outstanding person who contributed a great deal to Canada and to Canadian history.

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Propofol syndrome in children

Eric Wooltorton's report about propofol[1] reiterates the well-known fact that the use of propofol for sedation in critically ill children has been associated with a life-threatening adverse reaction characterized by metabolic acidosis, hemodynamic instability, multiorgan failure, lipemia, hepatomegaly and rhabdomyolysis.[2,3] Wooltorton speculates that this reaction, which he refers to as the "propofol syndrome," may be less common when the drug is used in children for procedural sedation or for induction or maintenance of general anesthesia. However, he contends that "significant harm can come from off-label use of agents whose pediatric safety profile is incomplete" and that "the known and theoretical risks of propofol should be explained to parents."

At the Hospital for Sick Children, propofol has been used in approximately 100 000 pediatric patients for sedation and general anesthesia without a single occurrence of the "propofol syndrome." This rate is less than the incidence of major perioperative complications.[4] Our experience is similar to that at other centres,[5,6] and thus the actual risk, if it exists at all, is minimal. Furthermore, a causal relation between propofol anesthesia and the syndrome has never been established.[2,3,7]

The suggestion that the "propofol syndrome" may occur in the context of single bolus administration or short-term infusion in children is incorrect. Accordingly, we stand by our practice of not citing this issue when we inform parents or guardians of the risks associated with propofol anesthesia in the preoperative interview.

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Eric Wooltorton's[1] statement that critically ill children, especially those with acute infections, should not be sedated with propofol in the intensive care unit is a well-known fact. This is the sole thrust of the March 2001 alert from the US Food and Drug Administration on this subject.[2]

Propofol is used safely in children around the world, so it is a considerable stretch to now suggest that the "[propofol] syndrome may be less common when the drug is used in less critically ill pediatric patients for short periods (e.g., for procedural sedation or for the induction and maintenance of general anesthesia)."[1] In this context, what does "may be less common" mean? Almost never or never? Is this a "theoretical risk" to be explained to parents?

Except for 2 cases reported by Finley and colleagues,[3] propofol has proven remarkably safe for anesthesia in children from the age of 3 weeks. For short procedures such as MRI, children with mitochondrial myopathies may be more safely anesthetized with propofol than with halogenated agents, barbiturates or nitrous oxide.[4]

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[The author responds:]

My article on propofol[1] highlighted the roles of *CMAJ*'s Health and Drug Alerts column: to emphasize

warnings from recent international "Dear Healthcare Professional" letters, to distill key messages when such letters are vague and to bring debates from more specialized bodies of literature to our general medical audience. Questions about the exact frequency and risk factors for a so-called propofol syndrome in critically ill children are certainly worthy of future systematic and rigorous research. However, I believe the real issue is not whether the syndrome truly exists, but whether a single advisory from the US Food and Drug Administration (FDA) in 2001 is sufficient to put the issue to rest. We know from the cisapride story that even multiple warnings can fail to have an impact on physicians' prescribing behaviours.[2,3] In the case of propofol, postmarketing adverse events (including deaths) continued to occur in Canada, despite the 2001 FDA warning, and were the reason that Health Canada issued its own warning.[4] I felt it wise to echo these concerns, to frame the debate for those who were unfamiliar with it and to recommend that patients be kept informed.

I can appreciate the letter writers' concerns about whether or not to include "theoretical risks" in preoperative discussions with patients and their families. Although I usually choose to inform patients of all serious adverse events (including those that are rare), I admit that in writing this column I should have better emphasized the difference between concerns about propofol's use for the long-term sedation of critically ill pediatric patients and its relative safety in other contexts.

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Snowmobiler's hematuria

Snowmobiling is a common recreational activity in many regions of Canada and other countries with winter snow cover, but snowmobilers are at risk for traumatic injuries.[1] I describe here a healthy man who experienced gross hematuria after long-distance snowmobiling. A MEDLINE search yielded no other reports of nontraumatic gross hematuria after snowmobiling.

A 40-year-old man experienced