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LETTER TO THE EDITOR

RESPIRATORY ARREST AFTER IV METOCLOPRAMIDE

Sir,

This is with reference to the letter from Dr. C. Madhusoodan in the Ind J. Anaesth 1994; 42:70 regarding "Respiratory arrest and cyanosis after IV metoclopramide".

We would like to report two cases with similar experience after metoclopramide iv. Both were young healthy adult females with no other systemic illness posted for laparoscopy as day care surgery. They had a preanaesthetic check up on the previous day and were classified as ASA I.

The first patient was induced with pethidine, thiopentone in routine doses, intubated with succinylcholine, maintained with gas, oxygen, halothane and another dose of succinylcholine. The intraoperative monitoring included EKG, NIBP, pulse oximetry and capnography, and was uneventful. At the end of the procedure, patient was responding to pain and was extubated after adequate recovery of respiration. As a prophylactic measure against PONV, the patient received 7.5 mg of metoclopramide intravenously. Immediately following this, the patient became apnoeic. The patient was ventilated with bag and mask on 100% oxygen and recovery of adequate respiration was noticed in 2-3 minutes. The patient did not desaturate during the apnoeic spell as she was receiving 100% oxygen before the spell also. The hemodynamics were unaltered and stable.

The second patient was taken up immediately after the above described case. After connecting the patient to the routine monitors mentioned above and securing the IV line, 7.5 mg of metoclopramide iv was administered from a different vial before induction. Immediately the patient flexed all the four limbs rigidly and whispered that she could not breathe. We injected 250 mg of thiopentone, held the mask with 100% oxygen for 30 seconds and introduced a size 3 LMA as the patient became apnoeic. We assisted ventilation with N_2O:O_2 66:33, halothane 1% and surgery was commenced. The patient started having spontaneous efforts after 4-5 minutes and was paralysed with 100 mg of succinylcholine. The rest of the procedure was uneventful and the LMA was removed at the end of surgery after adequate recovery of reflexes. Both the patients were discharged on the same evening when they were streetfit.

The vials of metoclopramide which were used for the above patients were sent for analysis to the Adverse Drug Reaction (ADR) monitoring cell of the department of pharmacology. The concerned batch of vials was withdrawn immediately. The vial which was used for the first patient caused convulsions and death in the mouse immediately. The experiment was uneventful when the vial used in the second case was tried on mice.

Biochemical analysis could not be resorted to as the amount was found insufficient. As few other vials of the same batch also did not produce convulsions, the possibility of a contaminant was thought of.

As the analysis was inconclusive, we hesitated to report. But after reading Dr. Madhusoodan's experience in children, we decided to report in order to create awareness among anaesthesiologists about the possibility of respiratory arrest after intravenous metoclopramide even in adults.

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Reference

1. Madhusoodan C. Respiratory arrest and cyanosis after IV metoclopramide. *Ind J Anaesth 1994; **42:** 70*