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Unilateral sensorineural hearing loss after general anaesthesia

We would like to highlight a case of profound and persistent unilateral sensorineural hearing loss (SSNHL) after general anaesthesia in a 38-year-old ASA II music teacher who underwent excision of right forearm melanoma. She had no history of pre-operative otological disease or symptoms of auditory dysfunction.

The anaesthetic consisted of pre-medication with midazolam, bicitra and ranitidine, rapid sequence induction with fentanyl 150 µg, propofol 200 mg, and succinylcholine 100 mg, and maintenance with isoflurane in 33% oxygen and 66% nitrous oxide with intermittent doses of fentanyl. Other drugs administered included cefazoline and dolasetron. The patient was positioned supine. Mean arterial pressure remained within 20% of the pre-operative levels throughout the operation. Blood loss was minimal, and the operation lasted 3 h. Extubation and recovery from anaesthesia were uneventful. The patient in the postoperative care unit received compazine and an additional dose of dolasetron. She had a pain score of 4 out of 10, no vomiting, and tolerable nausea so she was discharged home.

On the seventh postoperative day the patient reported persistent deafness in her left ear, which had begun immediately postoperatively. This was not associated with vertigo, tinnitus, or sensation of aural fullness or pain. There were no other otological symptoms and the right ear appeared to be unaffected. Results of her full blood count, erythrocyte sedimentation rate, and clinical chemistry were normal. The diagnosis of profound deafness in left ear was confirmed by audiogram.

Sensorineural hearing loss after anaesthesia is extremely rare. In the literature, the most commonly discussed aetiologies include cochlear membrane breaks,

perilymph fistulas, vascular pathology such as microemboli, hypoperfusion, vasospasm, drugs, and hypercoagulation [1]. Nitrous oxide was used in 90% of the reported cases of hearing loss [2].

In summary, the scarcity of reported cases and lack of detail in many of the reports to date make definite conclusions impossible and leave the apparent connection between anaesthesia and SSNHL conjectural. The reporting of additional cases such as this is encouraged to promote further understanding of this rare and unappreciated complication.

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Tissue adhesive as an alternative to sutures for securing central venous catheters

We read with interest the article 'Tissue adhesive as an alternative to sutures for securing central venous catheters' [1]. We agree with the use of tissue glue for catheter fixation. One of the authors has several years experience in using this technique for the securing peripheral intravenous cannula, arterial lines and central venous catheters.

We would, however, like to highlight some other points which were not illustrated in the correspondence. Whilst we agree that cyanoacrylate glues have a high tensile strength, the shear strength is not as great. Therefore, while acetone solvent will dissolve a bond, equally and perhaps more simply, the bond will be broken with a rotational action between the bonded items. The idea of intrinsic