should be weighed against the benefits before the drug is prescribed for enuresis or depression.'

Shaefer MS, Edmunds AL, Markin RS, Wood RP, Pillen TJ, et al. Hepatic failure associated with imipramine therapy. Pharmacotherapy 10: 66-69, Jan 1990 [1376]

NSAIDs

Kidney disorders: comment

Oberle GP, Stahl RAK. Nonsteroidal anti-inflammatory drugs: acute effects on the kidney. Deutsche Medizinische Wochenschrift 115: 309-314, 23 Feb 1990 [German; 39 references] [1458]

Peptic ulcers: comment

Cann PA. Non-steroidal anti-inflammatory drugs and peptic ulcers. British Medical Journal 300: 875-876, 31 Mar 1990 [1452]

Pancuronium bromide
see Anaesthetics interaction

Phenelzine
see Carbamazepine interaction

Pipecuronium bromide
see Anaesthetics interaction

Pyrimethamine + sulfadoxine

Oral lichenoid reactions: incidence study

515 Malay soldiers (mean age 27 years) were divided into 3 groups based on their current or recent use of 'Fansidar' [pyrimethamine + sulfadoxine] to determine what effect, if any, antimalarial prophylaxis had on any oral lesions. Group 1 (n = 186) had received pyrimethamine + sulfadoxine once-weekly for 9 weeks. 4.8% had whitish striae or plaques on their gingiva. 69% of this group were smokers, including 6 of 9 participants presenting with striae or plaques. Group 2 (186) had stopped taking the antimalarial medication 2 months prior to the study. One participant (0.5%) had a white plaque on the pterygomandubular raphe. 62% were smokers including the affected solider. Group 3 (143) had not received pyrimethamine + sulfadoxine for ≥ 4 months. No observable plaques or striae were seen; 61% were smokers.

Hence, there was a 4.8% prevalence of striae or plaques with the gingiva as the most common site of occurence. There was no correlation between smoking and the occurence of lesions. Data from Group 2 indicated that the lesions disappear quickly after drug withdrawal.

Zain RB. Oral lichenoid reactions during antimalarial prophylaxis with sulphadoxine-pyrimethamine combination. Southeast Asian Journal of Tropical Medicine and Public Health 20: 253-256, Jun 1989 [1308]

Ropivacaine
see Bupivacaine/ropivacaine

Sorbitol
see Theophylline/sorbitol

Sufentanil

First report of respiratory arrest after a single epidural dose: case report ✻[S]

After administration of a single caudal epidural dose of sufentanil 50μg and bupivacaine 0.25% with epinephrine 1: 200 000 20ml for repair of a perineal fistula, a 34-year-old woman was placed in the supine horizontal position and immediately complained of lightheadedness and drowsiness. The patient had pin point pupils and within 1 min went into respiratory arrest.

Oxygenation *via* a face mask with oxygen 35% + nitrous oxide 65% resolved the apnoea and peripheral cyanosis. After 2 doses of IV naloxone 0.1mg, spontaneous respiration returned. The operation was completed with the patient in the lithotomy position. During recovery, sensation in the lower extremities returned over 8 hours and the patient was discharged.

During administration of the epidural mixture, repeated needle aspirations had been negative for blood or CSF. HR remained stable throughout the the entire operation. ***'The only possible explanation remaining . . . must be an immediate, massive, selective vascular absorption of sufentanil from the site of injection, despite the fact that the solution employed by us did contain epinephrine.'***

Steinstra R, van Poorten F. Immediate respiratory arrest after caudal epidural sufentanil. Anesthesiology 71: 993-994, Dec 1989 [1378]

Sulfadoxine
see Pyrimethamine + sulfadoxine

Theophylline

Adverse effects: review

Tsiu SJ, Self TH, Burns R. Theophylline toxicity: update. Annals of Allergy 64: 241-257, Feb 1990 [139 references] [1296]

Theophylline/sorbitol

Diarrhoea in an elderly patient: case report and clinical study

A 65-year-old man, hospitalised because of pneumonia, was tube fed and received oral theophylline elixir. He had watery diarrhoea in excess of 1 L/24 hours with a stool osmotic gap of 206 mmol/L within 5 days. The tube feed formula was suspected, but diarrhoea persisted despite a change of formula followed by withdrawal of tube feeding.

The diarrhoea resolved when oral theophylline was replaced with IV theophylline. The patient was rechallenged when the medication was switched back from IV to oral theophylline elixir and the diarrhoea recurred.

These observations prompted a study of patients receiving theophylline elixir with diarrhoea in excess of 500 mL/day. Diarrhoea in 4 of 12 patients receiving tube feeding was not affected by stopping or re-introducing tube feeding, but the stool volume was markedly reduced in all 12 patients when theophylline elixir was withdrawn (from > 1.1 L/day to 400 mL/day). All patients continued to receive theophylline in IV or tablet form with no recurrence of diarrhoea.

According to the manufacturer, the theophylline elixir (a 'sugar free' formulation) contained sorbitol 65g/100ml elixir which is sufficient to act as a laxative in patients who are fasting or receiving tube feeding, when given qid according to the

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