

Public access defibrillation

To the editor:

In the October 2001 issue of *CJEM* the Canadian Association of Emergency Physicians Public Access Defibrillation (PAD) Working Group published their position statement in support of PAD programs.¹ This follows a similar endorsement by the Canadian Heart and Stroke Foundation.² While I applaud the efforts of our association in being proactive with regard to health technology assessment, I feel that a great impediment to PAD programs may come from the fact that most cardiac arrests do not occur in public places.

Survival to cardiac arrest is currently less than 5% in Ontario.^{3,4} Obviously, something needs to be done. While early defibrillation by first responders (firefighters, police, emergency medical services [EMS]) has been shown to improve survival to cardiac arrest,³ the potential impact of a widespread layperson PAD program in the community may not. In a study of 1373 cardiac arrest cases over a 5-year period in the Ottawa region, approximately 85% of cardiac arrests occurred in private homes, 10% on the street and only 5% in large public places.⁴ A similar study is under way in 21 Ontario communities. In addition, 2/3 of cardiac arrest victims were found to be in asystole;⁴ those cases could not be helped by defibrillation. Therefore, we can estimate that less than 3% of all cardiac arrest cases could benefit from such a PAD program. This being said, a person is 3 times more likely to survive if cardiopulmonary resuscitation (CPR) is performed immediately after collapse.⁵ Yet only 3% of the Canadian population knows how to perform CPR. Al-

most 9 times out of 10, nothing is being done before EMS arrive.⁵ If only 50% of cardiac arrest cases were to receive immediate CPR, survival to cardiac arrest could be improved from the current 5% to over 30%.⁶

With those statistics in mind, and with an international trial under way evaluating the outcome of PAD programs in North America (The PAD Trial), it may be premature to endorse any PAD program at this moment. It may be that if more resources were devoted to increasing the bystander rate of CPR in the population, even better results could be achieved. Such a program would benefit the whole population, not just the few and far between cases of cardiac arrest that occur in public places.

Let's be cautious before we endorse PAD programs.

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Propofol in the ED: Check your doses!

To the editor:

Doses of 16–33 mg/min for patient-controlled sedation were repeatedly quoted in Dr. Ducharme's commentary.¹ These doses would be expected to result in general anesthesia within 10 minutes! Propofol infusions in the range of 20–40 mcg/kg/min (i.e., 1.5–3 mg/min for a 70-kg patient) titrated to patient response with boluses of approximately 200 mcg/kg (15 mg) are more commonly used for procedural sedation. (Product monograph recommendations for surgical diagnostic sedation are for 25–75 mcg/kg/min after 0.5–1.0 mg/kg bolus over 3 to 5 minutes.)

I have difficulty understanding how Dr. Ducharme could author a commentary on propofol that repeatedly quotes infusion rates for sedation that are over 10 times those recommended and used clinically. Although Dr. Ducharme undoubtedly has experience with intermittent mini-dose titration of propofol, his commentary suggests this is not the case with administering propofol infusions. Readers who utilize Dr. Ducharme's recommended propofol infusion rates of 16–33 mg/min for sedation will quickly find themselves managing an apneic, unconscious patient. Dr. Ducharme's proposed study on pa-

For reasons of space, letters may be edited for brevity and clarity.