Etomidate in the ED

To the editor:

I read with interest Dr. James Thompson's review of the National Emergency Airway Management Course (NEAMC) in the January issue of CJEM.[1] The course is hands-on, up-close and interactive. It covers every aspect of emergency airway management. I found it invaluable and highly recommend it to every physician who practises any emergency medicine.

Like Thompson, I was struck by the different approach to rapid sequence intubation (RSI) advocated by our US counterparts. I agree with their limited use of midazolam, and I have seen many episodes of hypotension with midazolam induction doses of 0.1–0.3 mg/kg. I was particularly interested to learn about etomidate (Amidate), which, at 0.15 to 0.3 mg/kg offers the advantages of thiopental without the hypotension seen with barbiturates, benzodiazepines and propofol. My impression, judging from the feedback at the course, is that US emergency physicians use etomidate almost exclusively, except in bronchospastic and selected hypotensive patients, where ketamine seems to be the agent of choice.

Through Health Canada's Special Access Program, we have now used etomidate in 5 cases, with excellent results. I encourage other Canadian emergency physicians to take advantage of this alternative to gain valuable experience with an excellent induction agent that seems to be in a class of its own.

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Reference

1. Thompson JM. National Emergency Airway Management Course [media review]. CJEM 2000;2(1):59.

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