

# Propofol ampoule: Take care while opening

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## Abstract

To the Editor

I am reporting a cut injury which occurred whilst opening a Propofol ampoule (Fresenius Propoven 1%). In preparation to anaesthetize, the Propofol ampoule was opened which resulted in a laceration of 2 cms long and 0.5 cm in width and 0.5 cm in depth on the left thumb area (fig 1).

## Figure 1

Figure 1: Laceration measuring 2cmsx 0.5cmx0.5cm



It was seen by a plastic surgeon, he sutured the cut and said the laceration had just missed the digital nerve, and also I could not work as an anesthetist with that wound for almost 7 days.

Injuries while breaking ampoule is not uncommon. In Parker's study (1), the incidence of hand laceration secondary to opening glass ampoules was 6% and the prevalence of

visible old hand laceration was 26%. In another study published (2), the incidence density for ampoule injury was 4.1 per person year (PPY), which was similar to needle stick injury (4.5 PPY) with health care workers. There has been a report of laceration secondary to opening Propofol ampoule which required plastic surgery (3). Ali (3) continued to experience numbness in his finger. There has also been a lot of debate on how to open Propofol ampoule (4, 5), and this was probably triggered by anecdotal evidence of Propofol ampoule injury. Palmer et al (6) highlighted that opening of Propofol ampoule left spikes in 51.7% which can potentially cause injury.

Although breaking an ampoule has been made easy by having markers and using flip method, there is still a risk of injury which can occasionally cause permanent disability of the hand(3). Propofol ampoule is the most commonly used large ampoule amongst anesthetists, hence we should take necessary precaution to avoid a potentially irreversible damage to the hand.

## References

1. PARKER M. R. J.; *Anaesthesia*, 1995, vol. 50(8); 726-729
2. *Journal of Medicine and Biomedical Research* VOL. 3, NUM. 1, 2004, PP. 59-66
3. Ali PB. Persistent problem with Propofol ampoules. *Anaesthesia* 1997; 52: 1020.
4. Huda W, Khan RM. Opening an ampoule? Start from a scratch. *Can J Anesth* 2001; 48: 715.
5. Morrison WJ. Another cracking idea. *Anaesthesia* 1999; 54: 307-8.
6. Palmer J, Ball D. Opening propofol ampoules. *Anaesthesia* 1998 ; 53: 416-7.

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