My contention is that the commonly espoused belief that epinephrine cannot be used with lidocaine in digital blocks is not supported by the medical literature and that, in fact, the weight of evidence argues in favour of its use.

Secondly, the article that Dr. Moser cites as evidence of complications from direct epinephrine injection into digits describes the accidental injection of an adult dose of epinephrine from an auto-injector syringe (used to treat allergic reactions) into the thumb of a child.[2] This scenario differs from the use of lidocaine–epinephrine formulations for local anesthesia. The typical adult epinephrine auto-injector device delivers 0.3 cc (0.3 mg) of 1:1000 epinephrine. In contrast, lidocaine and epinephrine formulations used for local anesthesia contain epinephrine in a concentration of 1:100000. If 1 cc of anesthetic is used in a digital block, the delivered epinephrine dose is 0.01 mg, and if 5 cc is used (as in the clinical trials), this is 0.05 mg of epinephrine. The epinephrine dose delivered by an auto-injector is, therefore 6–30 times higher. In fact, 30 cc of local anesthetic would need to be infiltrated into a finger to achieve the same dose as the adult auto-injector.

As to the contention that epinephrine is unnecessary in most cases involving digital repair in the ED, I would agree. The reason I use it in practice is because it makes my job easier. I rarely require a tourniquet, the blocks last longer, and I am always reassured by the preservation of capillary refill to the finger. In the unlikely event that ischemia occurs, Dr. Moser correctly mentions phentolamine or terbutaline as rescue drugs. To date, I have not had reason to use either.

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SARS

To the Editor: In the September issue of *CJEM*, the CAEP Position Statement, "Implications of the SARS outbreak for Canadian emergency departments," states in Recommendation 9 (p. 347) that "Ontario has mandated 24/7 triage staffing by appropriately trained nurses, and this should become a national standard."[1] Although this is a laudatory goal it is important to point out that other trained health care professionals also perform triage in emergency departments in this country. In Halifax, our single tertiary care institution (Queen Elizabeth II Health Sciences Centre/Capital Health) has had paramedics performing triage (successfully) for over 10 years.[2] The goal remains the same: rapid, safe standardized triage by trained health care professionals.

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2. Cook S, Sinclair D. Emergency department triage: a program assessment using the tools of continuous quality improvement. J Emerg Med 1997;15(6):889-94.

Letters will be considered for publication if they relate to topics of interest to emergency physicians in urban, rural, community or academic settings. Letters responding to a previously published *CJEM* article should reach *CJEM* head office in Vancouver (see masthead for details) within 6 weeks of the article's publication. Letters should be limited to 400 words and 5 references. For reasons of space, letters may be edited for brevity and clarity.

Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.

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