We are reporting a simple alternative technique in the event of unintended dural puncture. As recommended by Moore for continuous spinal anesthesia, when dural puncture occurs, we aseptically insert a 20-gauge, 90-cm nylon epidural (Ephuslon, Tract Medical, Jaffrey, New Jersey) catheter with the wire stylet withdrawn 5 cm through the exiting 17-gauge Touhy needle. The epidural catheter is directed caudally and advanced 2–3 cm. Five milliliters of preservative-free lidocaine 1% (5 ml ampule ASTRA Pharmaceutical Products, Westborough, Massachusetts) is diluted with 15 ml of preservative-free saline (10 ml vial, ABBOTT Laboratories, North Chicago, Illinois). The resultant solution of lidocaine 0.25% has a specific gravity of 1.025. In order to avoid unilateral block and aorticocaval compression, the block is established in the following manner: 3 ml of lidocaine 0.25% was administered with the patient in lateral decubitus position. Five minutes following the initial injection, the patient is turned to the other side (lateral decubitus) and is kept on that side for an additional 5 min. At this time, the level is assessed. Following injection of 5 ml of 0.25% lidocaine, effective analgesia to a level of T9–T10 to ST5 was obtained within 60 s in seven of ten patients. In three out of ten patients, the sensory level was lower than T10 bilaterally, necessitating an additional 1 ml of lidocaine 0.25% that resulted in analgesia from T7 to ST5. Once analgesia was satisfactory, patients were kept in the lateral decubitus side of their choice. The spinal analgesia is reinforced approximately every 2 h, with the same solution and regimen as with the initial administration. All patients had received intravenous hydration with 1000 ml of Lactated Ringer's solution before epidural analgesia. There were no episodes of significant hypotension. Supplemental doses prior to delivery for perineal anesthesia were not required, because the sensory block extended to all sacral segments. No motor block or instrumental delivery occurred in any of the ten patients.

Of our ten parturients with dural punctures from 17-gauge Touhy needles, two developed postdural puncture headache. In one parturient, the headache was severe, necessitating an epidural blood patch. In two of the ten patients, lidocaine 0.25% did not provide adequate analgesia after an infusion of pitocin was initiated. However, satisfactory analgesia was obtained when fentanyl 6.25 μg was added to 3 ml of lidocaine 0.25% diluted with saline.

We believe this method is a simple and safe alternative for the management of unintended dural puncture. When used with low concentrations of lidocaine, this method results in effective labor analgesia and eliminates the need for a repeat epidural block with its complications. Furthermore, should such patients subsequently need anesthesia for a cesarean section, this can be accomplished by titrating additional small doses of a higher concentration of local anesthetic.

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REFERENCES

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High-pressure Uterine Displacement

To the Editor:—In obstetrical patients, prevention of the supine hypotension syndrome or aorticocaval compression is essential especially during conduction anesthesia. In our obstetrical suite, we have used a device similar to that described by Redick,1 an empty 3-l plastic bag used for urologic irrigation is connected to a short piece of plastic tubing that has a standard sphygmomanometer type of inflation bulb attached to its other end. The bag is placed beneath the operating table's mattress so that it is directly under the patient's right hip and is inflated to achieve uterine displacement.

In addition, we have available in all of our obstetrical operating rooms a device for emergency transabdominal jentilation. This device, as described by Millar,2 is capable of delivering 50-psi hospital-piped oxygen via a luer lock fitting through an intravenous cannula placed percutaneously into the trachea. Control of the jetted oxygen is effected by a thumb operated valve. The effectiveness of this ventilation technique has recently been shown by Thomas et al.3

Recently, we have noted these two devices give rise to a high pressure uterine displacer (fig. 1). The inflation bulb is replaced by a three-way luer stopcock that allows the high pressure oxygen to inflate the bag.

Placed beneath the operating table's mattress, the inflatable wedge is continuously ready for use. Unlike a fixed device, such as a foam rubber wedge, it is fully adjustable at all times during an anesthetic.

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Anesthesiology
70:165–166, 1989
Calculating the Potency of Mivacurium

To the Editor.—I am confused by some of the results reported by Savarese et al. in their recent paper on the pharmacology of mivacurium. Specifically, using the data supplied in table 1, I cannot reproduce the ED95 value of 0.081 mg/kg that they calculate. If one performs a log dose-probit transformation and linear regression analysis on only the first four groups (0.03–0.10 mg/kg), the resulting ED95 and ED90 values are 0.052 and 0.10 mg/kg, respectively (table 1). In fact, this estimate of potency is substantiated by the group of patients receiving 0.10 mg/kg that showed 95.7% twitch depression. If the ED95 was, in reality, 0.081 mg/kg, then a dose of 0.10 mg/kg should produce greater than 99% twitch depression; this was not the case.

The authors do not actually state in their paper which groups were employed in calculating the ED95 and ED90 values. However, since 100% twitch suppression cannot be plotted on a log-probit graph, it appears that only the first four groups (n = 36) could have been used. It would be helpful if the authors could explain in greater detail how they estimated drug potency.

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In Reply.—We appreciate the comments offered by Dr. Kopman. His letter reflects the need for a solution to a debatable question: How does one handle 100% or 6% twitch inhibition during construction of a dose-response curve for a neuromuscular blocking drug?

In our publication on mivacurium, we estimated potency of mivacurium during nitrous oxide-narcotic-barbiturate anesthesia using single-twitch stimulation of the ulnar nerve to evoke thumb adduction at 0.15 Hz. This stimulus parameter was used so that the characteristics of mivacurium block might be easily compared with past literature on other relaxants. The methodology is fairly extensively presented and debated in Donlon et al., where both single-bolus and cumulative dose-response curves for pancuronium were constructed.

Although we calculated an ED90 of 0.081 mg/kg in our paper, when we administered 0.10 mg/kg to nine consecutive patients, we observed

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**Table 1. Log-probit Transformation of Data from Table 1 of Savarese et al.**

<table>
<thead>
<tr>
<th>Dose (mg/kg)</th>
<th>% Effect</th>
<th>Log-dose</th>
<th>Probit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.03</td>
<td>9.4</td>
<td>−1.5228</td>
<td>−1.3106</td>
</tr>
<tr>
<td>0.05</td>
<td>43.7</td>
<td>−1.3010</td>
<td>−0.6137</td>
</tr>
<tr>
<td>0.07</td>
<td>75.3</td>
<td>−1.1549</td>
<td>0.6280</td>
</tr>
<tr>
<td>0.10</td>
<td>95.7</td>
<td>−1.0000</td>
<td>1.6955</td>
</tr>
</tbody>
</table>

Equation for the dose-response relationship as determined by linear regression (least squares) analysis of the above log-probit data: y = 5.8599x + 7.513, r = 0.998.

REFERENCE


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