CORRESPONDENCE

RESPIRATORY DEPRESSION AND PHENAZOCINE

Sir.—Dr. Swerdlow's criticisms (Brit. J. Anaesth., 34, 593) are valid and serve to show how much care is necessary in evaluating reports from different workers. Nevertheless I think that he would agree that my series indicates that, given appropriate combinations of drugs, complications such as respiratory depression and vomiting may be minimized.

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Reading

HYPERVENTILATION AND CEREBRAL DAMAGE

Sir.—It is always gratifying to read of careful investigations into the effects of anaesthetic methods, more especially when they have proved their clinical worth. Drs. Allen and Morris (Brit. J. Anaesth., 1962, 34, 696) have made a brave attempt to elucidate one of the interesting problems of modern anaesthesia, but unfortunately their results, as presented to us, seem open to criticism on several grounds.

In the first place there appears to have been but a feeble attempt to match the "control" series to the "experimental" series of patients in respect of (a) depth of anaesthesia, (b) drug combinations, (c) position of the patient on the operating table, (d) postoperative analgesia, or, most important, (e) duration of anaesthesia (the ratio of short (less than 120 min) operations to long (more than 120 min) operations in the case of the control series was 11 to 16, and in the case of the hyperventilation series 5 to 19). There is no information as to the comparative ages of the patients in the two series nor as to their physical condition. The only data given is that ten patients were rejected as unsuitable, but no grounds were given for the retention of the remainder.

In passing, it seems odd that in six patients out of twenty-four, attempted hyperventilation failed to lower carbon dioxide tension significantly. Some explanation should be provided for this observation, which can only be described as astonishing.

The authors go to considerable lengths to "explain away" the four patients in whom pulmonary hyperventilation was confirmed, but in whom there was no alteration in the c.f.f. test. Two at least of these may be accounted for by the fact that their basic anaesthesia (nitrous oxide and adequate curarization) was of the type which we would recommend as being suitable for supplementation by pulmonary hyperventilation.

However valid or otherwise these objections to the work may be, a basic difficulty remains. The real value of the test which the authors have selected as an indication of cerebral damage has always been open to question. This test manifests the relative duration under different circumstances of a dose of hexobarbitone, but its significance in terms of permanent cerebral damage as opposed to temporarily disordered function, perhaps of a very limited area, is quite unknown.

Even by this test the derangement following pulmonary hyperventilation is admitted by the authors to be slight and transient, and the wide clinical experience of the use of this adjuvant to light anaesthesia which has been gained in patients of all ages and physical conditions seems to us to outweigh conclusions based on such tenuous grounds.

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PIN INDEX SYSTEM

Sir.—Further to our earlier letter (Brit. J. Anaesth., 34, 591) in which we drew attention to the possibility of oxygen and nitrous oxide supply leads being connected to the machine the wrong way round. We would like to record that New Zealand Industrial Gases Ltd. have now modified the machine attachment by drilling it top and bottom as we suggested in our previous letter.

We enclose photographs showing the new attachment, longer and with two sets of holes (fig. 1), and the attachment fitted upside down (fig. 2).

As will be seen from the photographs, in contrast to the old fitting, the new one can only be connected to its correct yoke on the machine whether it is upside down or not.

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