Sir,—I thank you for the opportunity of replying to the erudite letter by Dr Keeri-Szanto, and appreciate his criticism of my paper. I accept that the “sleeping dose” of thiopentone may have had some influence on the patient’s responses, and also that the operations were on the whole not long enough for completely detailed appraisal of the drugs. However, I was interested to compare the drugs using a technique which resembled our usual clinical practice, and all the operations were comparable in that they were major abdominal operations. It would have been difficult to obtain a sufficiently large group if all the patients required surgery of duration longer than 2 hours. The initial dose of the analgesic chosen was similar to that of our normal clinical practice (we have never been convinced of the usefulness of using the “massive” doses of narcotics advocated by some workers). I must accept that some of the first dose of drug following induction underwent distribution rather than elimination, and this may explain why no difference was found in the times between induction and the first increment. This explanation would seem less valid, however, in explaining the lack of significant differences (with the exception of pethidine between 3 and 4) for the further increments.

The main contention of Dr Keeri-Szanto, that any individual patient will always demonstrate the same sign as an index of light anaesthesia, is not in accord with my own clinical experience nor is his contention that anaesthesia cannot be maintained with nitrous oxide and myoneural blocking drugs alone (Beaulieu, Goyette and Keeri-Szanto, 1967). The so-called “Liverpool technique” is practised widely in some centres, and its advocates do not rely on excessive premedication to achieve satisfactory anaesthesia. Many anaesthetists will agree that an individual patient may manifest, at one time, tachycardia, at another time sweating, and that neither of these signs indicate reliably an inadequate “depth” of anaesthesia, since that term has, in my opinion, little relevance in the presence of profound neuromuscular blockade.

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REFERENCE

ACCESS FOR EXTRADURAL BLOCK IN UNMOVABLE PATIENTS
Sir,—Extradural nerve block is being employed on an increasing scale for pain relief. Its ability to provide superior analgesia without respiratory depression is particularly valuable (Simpson et al., 1961). It is now a common procedure in our intensive care unit to provide analgesia mainly for patients with multiple trauma.

Positioning the patient in the conventional lateral or sitting position presents formidable difficulties as a result of pain induced in patients with bony injuries. These difficulties may be overcome by the use of the M.P.C. Steelnurse Portlift (fig. 1), which allows the immobilized patient to be raised vertically and permits access to the vertebral column. The device consists of one horizontal and five vertical arms which may be varied in both position and height. Thin sections of strong plastic which are slipped under the patient are attached to hooks on the vertical arms thus allowing elevation and horizontal rotation of the patient without limb movement. The apparatus is operated easily by one or two nurses.

By proper positioning of the plastic strips the appropriate area of the patient’s back is exposed for the performance of the extradural block. The distance between the two strips on either side of the exposed area determines the degree of vertebral flexion. Full elevation provides a space of 30–40 cm between the bed and the patient’s back (fig. 2). If preferred, the bed may be removed, allowing greater access. We have employed the method of Moore (1969) to introduce the extradural needle and catheter and in spite of the unusual position this has not proved difficult.

The advantages for these patients, in terms of pain relief, is enormous. The method could be used easily for providing extradural or spinal blocks for traumatized patients undergoing surgery for correction of lower limb fractures.

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Fig. 1. The patient-lifting device.