SIMPLE RESUSCITATION OF THE NEONATE

Sir,—Resuscitation of the newborn during Caesarean section or normal labour is a prime duty of the anaesthetist. Not uncommonly, neonates do not commence rhythmic respiration and require artificial ventilation. It is generally recognized that mouth-to-mouth or mouth-to-nose resuscitation is the most satisfactory method available for emergency use but the technique is aesthetically unpleasant and difficult in small babies.

To overcome this problem, I have devised a simple resuscitator, the components of which are available in every operating theatre. These comprise (fig. 1) a mask (infant inflatable rubber face mask), a connector and a mouth piece, the last two being accessories from a Bird's Respirator.

Fig. 1. Simple resuscitator for the neonate.
1 = mask; 2 = connection; 3 = mouth piece.

Fig. 2. The device assembled.

All these components can be assembled easily into one device (fig. 2) which is simple, light and comfortable. I have used this for resuscitation of neonates over the past 6 months, with encouraging results.

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TEST DOSES IN EXTRADURAL ANALGESIA

Sir,—I feel the letter from Dr J. A. Stirt (1978) regarding the use of a test dose in extradural block requires comment. If I have understood him correctly, he made his diagnosis that the extradural catheter had entered the subarachnoid space because fluid dripped back some minutes after the last injection, and on analysis this contained glucose at a concentration midway between that found in cerebrospinal fluid and blood. Neither of these points is valid.

It is a quite common experience to find fluid dripping back from the end of an extradural catheter if the end is left open to the atmosphere. Such dripping may continue for some time. Rapid changes occur in the injected fluid after entry into the extradural space. Local anaesthetic is absorbed quickly and there will be a tendency for all blood constituents which can cross capillary walls to equilibrate with the injected solution. Thus, it is no surprise that, after injecting a solution containing no glucose, there should be a measurable amount of glucose present 10 min after injection. Some years ago I collected fluid in this way from a number of patients undergoing extradural block. When analysed for lignocaine (2% had been injected) the concentration had always decreased, being as little as 0.5% 10–15 min after injection.

The events in the case of Dr Stirt can all be satisfactorily explained as a correct injection into the extradural space. A limited block was produced by a moderate dose of local anaesthetic and extended two segments higher by adding a further dose.

This case, far from strengthening the case for a test dose, in fact weakens it.

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REFERENCE


Sir,—Thank you for the opportunity to reply to Dr Scott’s letter. He feels my assessment of a clinical situation as a transdural migration of an extradural catheter is incorrect.

The question arises of whether or not the timing and rate of fluid return from the external end of an extradural catheter is of diagnostic significance in regard to the location of its internal orifice. I believe it is. In the case I described pink fluid returned at the rate of 1 drop every 3 s beginning 10 min after the last injection of anaesthetic. This rate of return occurred despite the fact that the end of the catheter was tightly capped and not “left open to the atmosphere”, and was far more rapid than that which occurs normally. In addition, return began 10 min after the last injection of local anaesthetic and not immediately. Since local anaesthetic is quickly absorbed, as Dr Scott points out, any fluid return would be expected to be maximal immediately following injection, not 10 min later.