FITEED TO DRIVE AFTER ANAESTHESIA

Sir,—In the third edition of Medical Aspects of Fitness to Drive (published by the Medical Commission on Accident Prevention), Dr J. A. Havard, Deputy Secretary, B.M.A., writes, "With most general anaesthetics, it is safer to advise against driving for 48 hours afterwards."

The apparent divergence of this advice from usual practice in Britain, coupled with the eminence of the author, has occasioned several queries from anaesthetists and the matter has come before the Anaesthetists’ Sub-Committee of the C.C.H.M.S. and the Council of the Association of Anaesthetists.

The time taken to achieve safe "road-worthiness" varies widely between different anaesthetic agents and depends on dose, metabolic fate of the agent and individual variation. It would be rare for an interval of 48 h to be necessary. There is no interval that could be recommended unconditionally for all situations; nevertheless, an interval of 24 h or "after a night's sleep" would be regarded normally as sufficient. Dr Havard's opinion must be presumed to be a personal one.

P. J. F. BASKETT
Honorary Secretary, Association of Anaesthetists
M. D. VICKERS
Chairman, Anaesthetists' Sub-Committee of the C.C.H.M.S.

EXTRADURAL ANALGESIA OR GENERAL ANAESTHESIA FOR ELECTIVE SECTION

Sir,—Prompted by the interesting article by Professor Downing and his colleagues (1979), may I offer some comments upon this subject? As these workers record and, as we suggested previously in the paper to which they refer (James et al., 1977), the optimal direction of tilt can rarely be pre-determined (possibly asking the patient which side she has preferred to lie on during the final trimester will provide a clue—we are at present investigating this possibility). The anaesthetist must observe the response of the mother to the first top-up of local anaesthetic in order to determine which direction of tilt is associated with the least aorto-caval compression. The rather considerable degree of neonatal metabolic acidosis found by Downing and colleagues (1979) in their extradural series was predominantly an infusion acidosis, of uncertain origin (possibly reflective of maternal discomfort or hypotension), but aorto-caval compression will have contributed to this.

The frequencies of maternal discomfort and hypotension among the patients who received extradural block were disappointingly high, and were close to those which have been quoted to me in personal conversation with anaesthetists elsewhere in this country and in North America. I believe that they reflect a failure to refine the technique of administration. It has been our custom during the past 2-3 yr to inject bupivacaine 0.5% plain into the extradural space in incremental doses. I suggest that it is partly as a result of this that only one patient among our most recent 100 who have received extradural block for elective section has developed hypotension to an extent which required the administration of ephedrine. I suggest that a phased extension of vasomotor blockade allows time for restabilization of maternal cardiovascular dynamics without an undesirable decrease in arterial pressure.

Another aspect of this technique is also useful in this regard. Following upon advice given to me by Dr Donald Moir of Glasgow, we now administer the first of the incremental doses (customarily 10-15 ml) with the patient in the semi-sitting (reclining) position. This again reduces the likelihood of hypotension, but it has served almost to eliminate unsatisfactory analgesia. Previously we had noted, in common with many other anaesthetists, that patients would frequently complain of suprapubic pain or discomfort when the uterus was marsupialized preparatory to suture. After putting Dr Moir's advice into practice, this phenomenon has become a rarity, and only six of our most recent 100 patients have required supplementary analgesia during the operation. It is noteworthy that, of these six patients, four received a total of only 16-20 ml of bupivacaine. Our dose of bupivacaine, given incrementally, is considerably greater than that generally reported by others. It ranges from 15 to 55 ml (mean 25.6 ml), 50 of our recent 100 patients having received 20-25 ml and 32 receiving 26-30 ml. The sensory block rarely extended more cephaled than T4, no maternal complications ensued, and in the absence of obstetric pathology all the infants had an Apgar-minus-colour score of 8/8.

In summary, I believe that if the local anaesthetic is administered in incremental doses, with careful assessment of the optimal posture for avoiding or reducing aorto-caval compression and of the attainment of an effective spread of sensory block, the occasional disappointments encountered in association with this method of anaesthesia for section will be markedly reduced in number. Such modifications undoubtedly are time-consuming. However, whilst I appreciate that this could cause inconvenience in the context of general or gynaecological surgery, I would not accept that to spend 30-45 min over the anaesthetic preparation of a patient for elective section poses an intolerable burden upon the smooth running of an Obstetric Unit.

J. SELWYN CRAWFORD
Birmingham

REFERENCES