CORRESPONDENCE

ADDITIONAL BLOOD-GAS VARIABLES FOR THE RATIONAL CONTROL OF OXYGEN THERAPY

Corrigendum

Sir,—In our paper on Additional Blood-gas Variables [1] there are important errors in the coefficients given for Equation (1) in Appendix 1. These should be:

\[ \begin{align*}
c_1 &= 2000 \\
c_2 &= 2045 \\
c_3 &= -15 \\
c_4 &= 2400000 \\
c_5 &= -31100 \\
c_6 &= 2400 \\
c_7 &= -15
\end{align*} \]

These differ from those given by Thomas [2] (and in our paper) in that the signs of the odd-numbered coefficients have been reversed.

Thomas achieves the same effect by making \( p \) (the virtual \( PO_2 \)) negative. However, this seems to us to be a logical absurdity, and therefore likely to be overlooked—as we did in writing the paper but not, we hasten to add, in performing the calculations. The BBC-Basic function used did give the correct results.

We are grateful to Professor Peter Byles of Syracuse, New York, for drawing our attention to this error and we apologize to readers who have been misled.

N. WILLIS
W. W. MAPLESON
Cardiff
M. C. C. CLAPHAM
Birmingham

REFERENCES

PREVENTION OF PAIN ON INJECTION

Sir,—Pain on i.v. injection of induction agents such as propofol, etomidate and methohexitone continues to be mentioned, but there is a method of relieving this which has been universally successful in our hands, and which is both quick and easy to perform. Before the introduction of the agent in question, 1% lignocaine 2 ml is injected through the indwelling needle, while an assistant maintains an occluding pressure distal to the injection site. After 30 s from the start of the injection, the pressure is released and the induction agent given. With this technique, we have had 100% success rate with more than 100 patients, many of whom have been unpremedicated. This has proved to be a far more effective means of minimizing the pain of these induction agents than other methods tried, such as pre-injection with lignocaine without pressure [1] or mixing with lignocaine [2] and easier than injecting to a fast-flowing drip if one is not already available.

A similar method has been described with etomidate and methohexitone [3]. However, we feel that it is worth reiterating this point with the introduction of propofol, which is an agent ideally suited for induction of anaesthesia in day case surgery, if the injection can be made totally pain-free.

J. P. BARKER
B. S. K. KAMATH
Edgware

REFERENCES

AN UNUSUAL COMPLICATION

Sir,—It is known that invasive techniques may lead to various complications, as reported in the literature. In certain patients it is difficult to insert correctly the central venous catheters.

During an exploratory thoracotomy, we inserted a 14-gauge central venous catheter to the right subclavian vein, using the direct i.v. technique, without problem. Nevertheless, fluid perfusion was not satisfactory, and we tried several times to reinsert the catheter, without success. During surgical exploration the surgeon confirmed that the tip of the catheter was at the azygos vein.

Because of its rarity, we think that anaesthetists should be aware of this event.

J. REIS
P. MAGALHÃES
V. N. de Gaia, Portugal

REFERENCES

ROUTINE USE OF ATROPINE IN OBSTETRIC ANAESTHESIA

Sir,—We were disturbed that in the recent Postgraduate Educational Issue, Dr Morgan, [1] repeated the old adage that atropine should always be given before the administration of suxamethonium. Whilst accepting that this is true for a repeat dose of suxamethonium, we are unaware of any evidence that a single dose of suxamethonium is likely to cause bradycardia.