area to ensure the health of dental staff when inhalation sedation is in use.

Finally, while we agree fully with the continued use of an agent of such unparalleled safety as nitrous oxide, we would hope that this would not prevent the continued practice of scientific validation of new compounds by research such as our own.

I. M. McMenemin
G. D. Parbrook
Glasgow

REFERENCE

ANAESTHETIC CONTRIBUTION TO MATERNAL MORTALITY

Sir,—The views expressed in the recent article by Morgan [1] could have some influence or bearing on the anaesthetic contribution to maternal mortality.

"Cricoid pressure must be applied before loss of consciousness..." seems appropriate only to a slow thiopentone induction. I gave up this timing years ago after the death of a patient from regurgitation provoked by a cough or hiccup as the thiopentone circulated and instead, after a rapid thiopentone induction, apply cricoid pressure as or when the patient loses consciousness [2-4]. Can cricoid pressure be described as "simple and effective" when it is frequently performed poorly [5]? It can be difficult to identify the cricoid cartilage or to apply pressure unless modifications of the original technique are used [6,7]. It may cause as many problems and difficulties as it prevents, and considerable emphasis and attention needs to be directed to its detailed teaching and supervision.

Early attempts at laryngoscopy before suxamethonium has taken its full effect, will not be made if anaesthetists place reliance not on cessation of breathing or relaxation of the jaw produced by thiopentone, but rather, on evidence of fasciculations in the patient’s feet. Electromyographically, the interval from start of fasciculations to maximum blockade appears to vary quite widely [8].

Suxamethonium in a dose of 100 mg seems excessive unless preceded by a small dose of non-depolarizing neuromuscular blocking agent. The response to this drug varies [8]: in one personal case, 50 mg was adequate for the entire emergency Caesarean section. I have supervised anaesthesia for Caesarean section in which 30 mg (five patients) or 20 mg (40 patients) was used to cover intubation following thiopentone 250 mg given rapidly into an i.v. infusion. Fasciculations in the hands were observed in order to time laryngoscopy and no difficulties were experienced with intubation.

On the subject of incidence of failed intubation, no reference was made to a report [9] describing only two failed intubations in 4260 obstetric general anaesthetics. With experience of 5500 Caesarean sections a year, it is our impression that obstetric patients prove no more difficult regarding tracheal intubation than their non-obstetric counterparts. Moreover, it can be counter-productive and costly to perpetuate this view, directing attention away from the deficient ability and experience of the intubator with the need for more teaching and supervision. Various factors cited, including full dentition and hand applying cricoid pressure, interfere more with insertion of the laryngoscope, with which trainee anaesthetists also exhibit difficulties. In addition, it is doubtful that "difficult" intubation occurs with any greater frequency or severity in obstetric than in other fields of surgery, and most techniques of intubation are still applicable and valuable despite the presence of cricoid pressure.

R. Williamson
Durban

REFERENCES