wounds and wet surgical drapes would all reduce the tolerable temperature gradient); however, the above calculations serve to demonstrate that thermal balance may not be upset as badly as suggested. Indeed, the combination of warm i.v. fluids, heated humidified inspired gases and unwarmed towels to increase patient insulation resulted in increases in mean skin temperatures, core body temperature and calculated total body heat in patients undergoing intra-abdominal surgery [3, 4]. We would wholeheartedly endorse efforts to increase the thermal insulation of patients undergoing major surgery, especially if the operating theatre temperature is low, but other methods of minimizing heat loss must not be neglected.

M. M. Imrie
G. M. Hall
London

REFERENCES


POSTOPERATIVE PATIENT-CONTROLLED ANALGESIA

Sirs—I should like to comment on the Proceedings of the Anaesthetic Research Society in which Thomas, Heath and Rose reported a study of the effects of psychological variables and pain relief system on postoperative experience of pain [1].

I have used Cardiff Palliatores for patient-controlled analgesia (PCA) for virtually all my patients having major surgery since 1984 at Lewisham Hospital. I was a participant in the first of the current trials on the use of PCA for postoperative pain relief at Lewisham Hospital.

In common with Thomas, Heath and Rose, my experience has been that, where the PCA machine is offered to a patient after operation, without adequate explanation, adequate pain relief can still be achieved by the patient.

The suggestion in this paper is that psychological testing may permit patients with a high level of anxiety and neuroticism to be provided with postoperative analgesia, when a department is unable to provide each patient with PCA technology, and is of benefit in these circumstances. However, I believe that this should only be a temporary expedient in the development of PCA usage, within an individual department.

My experience has been that the ability to offer PCA to every patient requiring major surgery, and liable to require considerable amounts of analgesics following surgery, carries a major benefit in improvement of coping exhibited by these patients before operation. Most patients comment favourably on the availability of PCA, and those who have had previous surgery with traditional techniques of postoperative analgesia are particularly enthusiastic about the technique.

As PCA allows the patient to choose whatever pattern of postoperative analgesia they require, one can reliably assure the patient of the technique’s success.

I believe that every Department of Anaesthesia should have a sufficient number of machines to allow all patients requiring major surgery to have PCA available for their use.

J. M. Cundy
Lewisham

REFERENCE


Sirs,—Thank you for allowing us the opportunity to comment on Dr Cundy’s letter. We would be the first to acclaim his enthusiasm and effectiveness in introducing PCA to Lewisham Hospital, without which our study would not have taken place. We, too, hope that every patient for whom PCA is suitable could be assured the use of a machine. The unpalatable fact is that we have not achieved this, and many hospitals do not have one machine. Lewisham Hospital’s original Cardiff Palliatores are well over 6 years old; patients in our studies all used modern equipment kindly loaned by the manufacturers, but we are still having difficulty obtaining funds for purchasing new machines.

Our aim was to show who might benefit most when insufficient machines are available—a situation that we believe all hospitals will go through as they build up experience and equipment. A necessary element of the design of these studies was that patients would not receive prior information about the postoperative analgesia regimen. Preliminary analysis of the results yields the interesting incidental finding that patients’ pain relief was comparable to that found in other trials in which great stress was laid on the need for prior familiarization with the equipment. Further, no patient in our studies has failed to use the machine, although it has been suggested to us that almost 5% of patients will not “push the button”. It seems at least possible that a few patients may be frightened by preoperative information. Our reaction to this has been to devise a patient information sheet designed to be informative and reassuring to patients. Time will show if high acceptability rates can be maintained in this way.

Finally, while we feel proud that anaesthetists have been leaders in this field, there is no reason why the cost of the equipment should compete with anaesthetists’ other legitimate needs—the benefits of PCA (after those to the recipient) extend into nursing and the surgical specialties (earlier mobilization and reduced length of stay). The equipment should be treated as general hospital equipment purchased from Unit funds, recognizing its major contribution to overall quality of care.

V. J. Thomas
M. L. Heath
Lewisham