INTRATHecal Diamorphine–Bupivacaine DURING LABOUR

Sir,—In their study of pain relief during labour using incremental diamorphine and bupivacaine via an intrathecal catheter, Dr Kestin and colleagues [1] made no reference to the first reported use in labour of “single-shot” intrathecal morphine [2]. Had they felt able to do that, their interesting paper might have shed further light on the side effects. Both studies described side effects and both emphasized the high incidence of pruritus (75–100%). In the earlier paper [2], itching of the face and especially of the nostrils—for which a neuronal mechanism was invoked—signalled the onset of a working spinal opioid “block”.

We investigated this apparently trivial symptom [3–6], and came to the conclusion that facial itching in particular, associated with spinal opioid administration, may have a neuronal origin, with an encephalitogenic “itching centre” in the floor of the fourth cerebral ventricle associated with the nucleus of the trigeminal nerve and bounded cranially by the auditory nuclei and caudally by the inferior cerebellar peduncles [3, 5]. Not everyone agreed with us [7].

Pruritus, of course, may also occur from extradural injection of opioid, and we agree with Welchew and Thornton [8]: “The very rapid onset of itching in a region remote from that of application of the epidural narcotic (maxillary division of the trigeminal nerve) suggests a direct neuronal mechanism rather than an indirect one operating through the systemic distribution of absorbed fentanyl.”

The work of Kestin and colleagues [1], Scott and colleagues [2–6], Welchew and Thornton [8] and of ourselves lends support to the idea of a neuronal mechanism to account for the pruritus associated with spinal opioid administration in man.

Anaesthetists who use spinal opioids, especially in labour, might help to confirm or refute this hypothesis by reporting details of pruritus, including the times of onset and offset, the exact anatomical distribution (was it segmental?), the influence of local anaesthetic agents and the timing, effect and dose of opioid antagonists.

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References


The UNITED KINGDOM AS SEEN BY A JAPANESE ANAESTHETIST

Sir,—Through the visiting programme of the Japan Society of Anaesthesiology, I spent one and a half years as an academic visitor to the University of Edinburgh, and was able to experience the atmosphere of clinical practice and observe many differences between British and Japanese ways.

In Japan, with a population of 120 million, about 8000 candidates pass the national examination annually to become medical practitioners after 6 years of education. Legally, anaesthetists are not allowed to practise as specialists without a further qualification, termed “Registered Anaesthetist” (Hyōbō in Japanese), which requires 2 years training. Thereafter, a “Board-Certified Anaesthetist (Shidō)” of the Japan Society of Anaesthesiology requires 5 years experience and success in a two-stage examination consisting of an MCQ and a written paper, a viva voce stage examination consisting of an MCQ and a written paper, a viva voce and practical assessment. Hyōbō and Shidō are more or less equivalent to the D.A. and F.R.C.A. Anaes., respectively. At the end of 1991, there were about 9500 registered and 2700 board-certified anaesthetists.

We have neither the NHS nor its career structure; there is no anaesthetic room and no trained anaesthetic assistant such as an operating department assistant or anaesthetic nurse. Some agents available in Europe are not available in Japan at present, for example propofol, atracurium and EMLA. On the other hand, we are able to use sevoflurane.

The number of operations performed per operating room in Japan is generally smaller than that in Britain, and the primary reason, I feel, is the long duration of operations. In the TV commercial film of Mazda, the Japanese car company, an employee who wears a white cap, white mask and white gloves, inspects a car, changing gloves one after another, and says at long last, “OK.” with a Japanese accent! Japanese consumers require that a...
company should produce a car of perfection; such perfection is also expected of Japanese doctors; this may prolong operations.

British procedures, both surgical and anaesthetic, are quick and flexible but sometimes, I feel, rather less refined. Sterile techniques are often less thorough. To my surprise, spontaneous ventilation can be maintained with high-dose opioids and, to my astonishment, little happens, despite an increased measured end-tidal carbon dioxide concentration. In addition, the duration of hospital stay after surgery in Britain is usually shorter than that in Japan. I cannot but wonder if the tissue itself of British patients has more powerful healing abilities!

Morphine is used widely for postoperative pain relief in Japan. However, the required dose for weight is relatively small, and if I were to switch to another according to the British anaesthetist's procedure to feel sure that I would find a greater incidence of respiratory depression in Japanese patients. Sadly, I have no objective data to support this observation. Nevertheless, some British anaesthetists agreed with my observation and admit that they would give reduced doses to Oriental patients. It may be interesting study the difference between the races.

In both countries, nowadays, the young seem not to be keen on religion. However, Christianity is as rooted in British feelings as Buddhism and Confucianism in Japan, and expressed by rather dry and rational feelings in the U.K., but more emotionally in Japan. These differences make organ transplantation from brain-dead patients possible in the U.K. In Japan, brain death has not yet been accepted legally. Although more than 30 liver transplantations have been performed, all have been from living donors (except for one occasion when an imported liver from a brain-dead donor was used). The first heart transplantation was carried out in 1968, and the recipient lived for 83 days. However, the surgeon fell under suspicion of ordering the donor and a second attempt has not yet been made.

In conclusion, I would like to express my gratitude again to all of the colleagues I have met in the U.K. for their help. Every experience gave me opportunities to reassess my views. The Japanese are so ready to speak Japanese: it is a problem for us to demonstrate the fruits of our efforts to the world. I hope that we shall be able to use this visiting programme as a significant bridge between our countries.

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ASPIRIN, EXTRADURAL ANAESTHESIA AND THE MRC COLLABORATIVE LOW-DOSE ASPIRIN STUDY IN PREGNANCY (CLASP)

Sir,—An editorial by Dr Macdonald [1] discussed the potential risk of extradural haemotoma after extradural block in patients taking aspirin, and suggested that women taking aspirin during pregnancy should stop 7-10 days before delivery and have a bleeding time performed before extradural block is undertaken.

Even with small doses of aspirin (60 mg daily) the bleeding time may be prolonged because aspirin irreversibly inhibits cyclo-oxygenase in platelets [2]. A large multicentre randomized placebo-controlled trial (CLASP) [3] of the effects of aspirin 60 mg daily on the incidence of pre-eclampsia and its sequelae currently is being conducted, under the auspices of the Medical Research Council, in more than 200 hospitals in Britain and elsewhere. More than 7000 women already had been included in this study, and so far post-delivery data are available for more than 5000 women. The co-ordinators and collaborators remain blinded to the interim results, but a data monitoring committee (chaired by Professor Sir Richard Doll) reviews the unblinded data regularly. In view of the concerns that have been raised about extradural anaesthesia, these were reviewed in detail last year, and the data monitoring committee reported that: "The present position is that 1069 women are known to have had epidurals by the end of January 1991. Fifty-six adverse reactions, in the broadest sense of the term, have been reported in relation to epidurals, 26 in women on aspirin and 30 in women on placebo. Haemorrhage has been reported on three occasions, in all instances limited to blood stained fluid in the cannula during treatment. One was in a woman on aspirin and two were in women on placebo. None of the other adverse reactions reported appear likely to have been due to haemorrhage. Aspirin had been stopped 23 days before delivery in the one case on aspirin, and placebo had been stopped 23 days before delivery and an unknown time before delivery in the other two cases". After a subsequent review in November 1991, it was reported that no further extradural bleeding had been recorded after an additional 592 extradural injections. Review of the data for women taking aspirin during pregnancy is at present on hold, and will not be continued until further evidence indicates that such an approach is justified.

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Correspondence

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Co-Chairman, MRC Working Party for CLASP


Sir,—Thank you for the opportunity to read this letter from Drs de Swiet and Redman. In their letter they state quite rightly that the bleeding time may be prolonged even with low doses of aspirin (60 mg daily). Consequently, all patients in the CLASP trial who have ingested aspirin are likely to have a prolonged bleeding time. The obstetric anaesthetists' anxiety concerning the siting of an extradural block in a patient who has ingested a low dose of aspirin is not that there will be an increased incidence of vessel puncture, but that, should such a puncture occur, then bleeding into the extradural space will be prolonged as a result of the ingestion of the aspirin. What we do not know is how much bleeding will occur in relation to prolongation of the bleeding time. Will the volume of blood released into the extradural space from a vessel puncture be sufficient to cause a clinically significant extradural haemotoma?

I reiterate that the best test of platelet function after aspirin ingestion is estimation of the bleeding time. This is more relevant than a full clotting screen. I suggest that, with attention to detail, a bleeding time can be performed reliably and reproducible results achieved.

Nevertheless, in view of the fact that patients in CLASP are ceasing aspirin ingestion at about 37 weeks, it would appear that