


Sir,—Thank you for the opportunity to comment on the interesting points raised by Drs McSwiney, Joshi and McCarroll.

Do we overestimate blood loss in total hip replacement (THR)? Obviously, we think not. In THR—either cemented or uncemented—complete haemostasis is difficult to achieve and there is inevitable loss into the wound and around the deadspace created by the prosthesis. This may continue for 48 h or more after operation and is not accounted for in either the visible operative loss or the postoperative loss collected in the drains. However, it is revealed in the 10-day postoperative haemoglobin concentration, which is smaller than expected from measured loss. An accurate assessment of total blood loss in THR should therefore include the postoperative haemoglobin deficit (preoperative haemoglobin—postoperative haemoglobin).

Our data [1] showed that, in the transfused group, for whom average measured blood loss was 968 ml, the average haemoglobin deficit was still 2.2 g dl⁻¹. In the untransfused Jehovah’s Witnesses, the average haemoglobin deficit was 4.8 g dl⁻¹.

We have examined further the records of 503 consecutive patients who were transfused during uncemented THR. The average haemoglobin deficit was 1.92 (SD 1.43) g dl⁻¹ (95% confidence interval 1.87–2.12 g dl⁻¹). In 36 patients (7%) the postoperative haemoglobin concentration was greater than the preoperative value—in only eight patients (1.6%) by more than 1 g dl⁻¹ and in two of these (0.3%) by more than 2 g dl⁻¹.

Although McSwiney, Joshi and McCarroll mention the PCV as a criterion for transfusion, they do not specify if the preoperative value alone is used or if further measurements are obtained. May we suggest that they measure the haemoglobin deficit after operation, to show how accurate has been their assessment of transfusion needs?

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Sir,—Recently, in this hospital an on-call anaesthetist received a call at 05:00 telling him of an emergency Caesarean section and meeting expectant mothers at first booking. This latter suggestion may be radical, but many problems relating to pain relief and anaesthetic screening could be dealt with at that time.

We would be grateful if any readers could supply ideas to deal with a communication problem that we believe exists throughout the world.

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VENOUS SEQUELAE OF DICLOFENAC

Sir,—We refer to a letter, "Venous sequelae after i.v. diclofenac" [1]. We have been using i.v. diclofenac as analgesia for adenotonsillectomy in children. Diclofenac was compared with papaveretum in a double-blind, randomized controlled trial.

In an attempt to reduce the incidence of reported thromboembolism around the injection site [2], we diluted diclofenac (Voltarol 75 mg in 3 ml) in 5% glucose to produce a 1-mg ml⁻¹ solution. A dose of 1 ml kg⁻¹ was given after induction of anaesthesia and the injection site was inspected at injection, on waking and 15 min and 1, 4 and 24 h thereafter. There was no pain, thrombosis or inflammation at any time in any of the 20 patients who received i.v. diclofenac.

There were no significant differences in postoperative comfort requirements for extra analgesia, nausea, vomiting or peroperative bleeding compared with the group receiving i.v. papaveretum.

Diclofenac is unlicensed for i.v. administration in the United Kingdom because of insufficient clinical information (personal communication, Ciba Geigy). Choice of diluent and volume of dilution are both important factors in the prevention of venous sequelae [2]. We have shown in this small group of children that diclofenac was safe and effective.

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Sir,—From our experience in adults and a limited one in children, we observed that the nature of the diluent had no effect on the analgesic effects or potency. Glucose 5% may be more appropriate in the paediatric age group.

I feel that, at a dose of 1 mg kg⁻¹, a dilution of 1 mg ml⁻¹ may be a large volume of injectate and 5 mg ml⁻¹ would be more appropriate and could be given by infusion. I have used it in this way in only a few paediatric orthopaedic patients, without side effects.

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