SIR,—Thank you for the opportunity of replying to the comments of Dr Williams. The design of a study to examine cardiovascular changes during induction of anaesthesia is difficult. Our initial aim was to examine the effects of the anaesthetic induction agents alone. Our pilot study showed that doses of the induction agent sufficient to induce anaesthesia in unpremedicated patients resulted in anaesthesia of less than 3 min. We decided therefore to supplement anaesthesia with other agents used commonly in clinical practice. As supplementary drugs were given to all study groups, we feel that the observed pharmacological differences may be interpreted as those produced by the anaesthetic induction agents.

The ventilatory differences between the drugs used in our study again make study design difficult. Hypoaxemia and hypoventilation produce cardiovascular effects, although I am uncertain of their relevance over the time scale of our study. Intermittent positive pressure ventilation (IPPV) also produces cardiovascular effects. To minimize this between drugs with differing ventilatory depressant effects, an apnoeic period of 30 s was chosen.

Increases in $P_{\text{ACO}_2}$ over the period of the study are unlikely to have been significant, as ventilation was assisted using a Bain circuit with a high fresh gas flow to minimize rebreathing. A pulse oximeter was used in the majority of patients and hypoxaemia, which occurred rarely, was transient.

M. PRICE
St Mary's Hospital
London

ANTEPARTUM ASSESSMENT FOR ANAESTHESIA

SIR,—In response to the letter by Cody and Johnston [1], we offer our solution for reducing the likelihood of unanticipated anaesthetic problems occurring out of hours when senior help may not be readily available.

In our department, a simple card file system has been in operation for the past 10 years. This was initiated after episodes of "failure of communication" occurred, the obstetricians hypothesizing that the anaesthetists were either too late or insensitive to the need of the doctors to divulge information relevant to the potential anaesthetic management of an obstetric emergency. However, the problem of communication between anaesthetic staff was also found to be at fault in several cases. Patients are entered into the card file via three main routes: (1) At an antenatal clinic where the obstetrician identifies a potential anaesthetic risk or problem, such as problems establishing extradural or subarachnoid block, difficult or failed intubation, allergy or anaesthetic drug sensitivity.

In the first instance, patients are seen during the same antenatal clinic visit by a member of the anaesthetic department, usually a consultant. The potential problem is established, and an outline plan for their management is recorded on a filecard with basic obstetric details, including likely date of confinement. The period after consultation permits correspondence with other hospitals to obtain old notes and to request appropriate specialist advice. In the third instance, details of the anaesthetic problem encountered and its solution are recorded in case of a future confinement.

The merit of this simple system is that it is easy to use and update. It is available in the anaesthetic office area adjacent to the delivery suite theatres, and trainee anaesthetists are encouraged to browse through the card file. "Pending" problems (those patients approaching term) are filed separately at the front of the file; other cards are filed alphabetically. Any patient whose name appears on our card file is issued with a yellow sticker which is applied to the front of their notes. This indicates that when the patient is admitted the on-call anaesthetic staff are to be informed. After delivery, in the event of anaesthetic intervention, the nature of the management and the outcome are recorded by the attending anaesthetist. Equally relevant is the observation that no anaesthetic involvement was required.

We have found that, in a hospital with approximately 6600 deliveries annually, we have successfully reduced, not eliminated, the incidence of the 'phone call which concludes "and by the way...""

D. R. UNCLE
L. E. S. CARRIE
John Radcliffe Hospital
Oxford


SIR,—I have every sympathy with Drs Cody and Johnston [1] over their difficulty in perceiving obstetricians and their patients to refer expectant mothers with medical problems for anaesthetic consultation. The need for an antenatal referral, for example for diaphragmatic hernia or congenital heart disease diagnosed in utero, is much rarer. To achieve prompt referral for a maternal problem, two hurdles must be overcome. Firstly, seeing the mother during pregnancy must solve the problem and, second, the need for anaesthetic referral must spring to mind. It is a sad fact that in many centres one or both of these hurdles may not be overcome, possibly because a mother may rarely see an obstetrician or visit hospital for antenatal care. Nevertheless, to see every booked mother would be a major undertaking in many units, beyond the scope of anaesthetic departments.

I attempt to solve the problem by writing an angry letter every time we are taken by surprise as were Drs Cody and Johnston, and by setting aside a regular time each week for anaesthetic referral.

F. REYNOLDS
St Thomas' Hospital
London


SIR—Thank you for the opportunity to reply to Dr Reynolds' letter.

The problem of mothers not attending for antenatal visits is, I believe, beyond the anaesthetic remit. However, with the greatest extradural rates up to 50% and with an increasing Caesarean section rate there may be a case for seeing mothers antenatally. I wonder if informed consent or explanations given in the heat of labour would be valid in the current litigious era.

M. CODY
J. JOHNSTON
Enniskillen

The merit of this simple system is that it is easy to use and update. It is available in the anaesthetic office area adjacent to the delivery suite theatres, and trainee anaesthetists are encouraged to browse through the card file. "Pending" problems (those patients approaching term) are filed separately at the front of the file; other cards are filed alphabetically. Any patient whose name appears on our card file is issued with a yellow sticker which is applied to the front of their notes. This indicates that when the patient is admitted the on-call anaesthetic staff are to be informed. After delivery, in the event of anaesthetic intervention, the nature of the management and the outcome are recorded by the attending anaesthetist. Equally relevant is the observation that no anaesthetic involvement was required.

We have found that, in a hospital with approximately 6600 deliveries annually, we have successfully reduced, not eliminated, the incidence of the 'phone call which concludes "and by the way...""

D. R. UNCLE
L. E. S. CARRIE
John Radcliffe Hospital
Oxford