


Sir.—Drs Kitching and Rice describe an interesting case of puerperal extradural abscess after normal delivery with extradural analgesia. A similar case was described by Male and Martin [1], who reported an extradural abscess that developed 6 days after normal delivery in a 22-yr-old woman who also had not received extradural analgesia. This patient had been admitted 10 days before delivery suffering from infective hepatitis with hepatocellular dysfunction and jaundice, whereas the patient described by Drs Kitching and Rice was presumably healthy.

I agree that it is possible for an extradural abscess to occur after extradural catheterization without a causal relationship existing. However, I would emphasize several points. The incidence of spontaneous extradural abscess in the general hospital population is estimated at 0.2-1.2 per 10 000 which, indeed, is greater than the reported incidence of extradural abscess after lumbar extradural analgesia in obstetric patients, as pointed out by Drs Kitching and Rice. However, these populations are not equivalent. Closer inspection of reports within the general population demonstrates a high incidence of co-existing chronic disease, which is a risk factor for compromised immunity, and a predilection for the older age group, the majority of cases being patients older than 50 yr [2, 3]. In contrast, the average parturient is young and relatively healthy compared with the general population. Therefore a direct comparison of relative incidence between the obstetric population and the general population is inappropriate and statistically unsound.

I believe there is strong evidence of a causal relationship between the use of extradural anaesthesia and the development of an extradural abscess in our patient. This is supported by a close temporal relationship, correspondence of the location of the abscess and the site of extradural catheter insertion, and growth of the likely infective organism from a skin lesion at the puncture site.

Whilst Drs Kitching and Rice have demonstrated that extradural abscess can develop in the puerperium without obvious cause, I believe that extradural catheterization remains a risk factor for development of this serious condition in obstetrics and in other specialties, and would reiterate the importance of meticulous aseptic technique when performing these procedures.

Drs Vasdev and Leicht make pertinent comments regarding aseptic technique for extradural catheter insertion. However, I would draw to attention possible neonatal complications that may arise from maternal transdermal absorption of iodine from iodine-containing skin disinfectants. Neonatologists in our institution have shown recently that mothers exposed to topical iodine-containing antiseptics immediately before delivery had concentrations of iodine in their breast milk twice those of non-exposed mothers, and that this appeared to be linked to an increased incidence of transient neonatal hypothyroidism [4]. Iodine absorption would probably be minimized by the practice of rinsing off the iodine with 70% alcohol as recommended by Vasdev and Leicht, but in our delivery suite it is now policy to avoid completely the use of iodine-containing skin disinfectants.

We have favoured polyurethane dressings such as Tegaderm (3M) as dressings for extradural catheter sites because of their excellent fixation properties. Vasdev and Leicht cite evidence that these dressings may increase bacterial colonization, which indeed is of concern; we are currently reappraising usage in our practice.

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THE LARYNGEAL MASK AND INTRAOCULAR SURGERY

Sir,—We were interested in the article of Lamb, James and Janicki on the effect of the laryngeal mask airway (LMA) [1] on intraocular pressure [2]. In their conclusion, the authors mentioned the potential risk of loss of airway control with the LMA during general anaesthesia for intraocular surgery. This risk is not theoretical, but a practical disadvantage of the method, as the anaesthetist does not have access to the patient’s airway during surgery.

We describe two patients who recently underwent intraocular surgery under general anaesthesia (thiopentone, fentanyl, enflurane in an oxygen-nitrous oxide mixture and vecuronium). In both patients, intraocular pressure was monitored with the LMA. We found no evidence of any increase in intraocular pressure assessed by reading the intraocular pressure monitor. This monitor relies on an open system, and thus the possibility of a rise in intraocular pressure arising from the use of the LMA could not be confirmed.

Intraocular surgery is a high-risk procedure, and the use of an LMA for airway control in this setting is important. In our experience, the inability of the anaesthetist to gain convenient control of the patient’s airway during the procedure is a major hazard. Because of our experience, we have discontinued the use of an LMA for airway control in intraocular surgery.

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BRAIN PARTIAL PRESSURES OF ISOFLURANE AND NITROUS OXIDE

Sir,—We read with interest the article by Dr Thornton and colleagues [1], but wish to comment on the methods used. Thornton’s group used isoflurane or nitrous oxide, changed randomly in three consecutive 10-min periods. They do not state which anaesthesia system or what fresh gas flows they used.

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