CORRESPONDENCE

5. Brimacombe J, Berry A. A proposed fibreoptic scoring system to standardise the assessment of laryngeal mask airway position. Anaesthesia and Analgesia 1993; (in press).

Sir,—Thank you for the opportunity to respond to the letter of Drs Brimacombe and Berry. Their results clearly indicate that an adequate dose of induction agent provides as good insertion conditions for the laryngeal mask airway (LMA) as neuromuscular block. We have not suggested that neuromuscular block be used routinely in all patients. We feel that an adequate depth of anaesthesia is necessary before an attempt is made to introduce the LMA. Where the surgical requirements demand muscular relaxation and controlled ventilation, we see no harm in inducing neuromuscular block before securing the airway with an LMA as an alternative to either an adequate dose of i.v. anaesthetic or an inhalation agent.

L. N. YADDANAPUDI
L. KASHYAP
New Delhi, India

PREOPERATIVE FASTING GUIDELINES FOR CATARACT SURGERY UNDER REGIONAL ANAESTHESIA

Sir,—We welcome the editorial by Professor Strunin [1] on preoperative fasting guidelines, recommending clear fluids in healthy patients undergoing elective surgery. We have gone further for patients who undergo cataract surgery; they are often elderly and suffer from systemic disease which requires medication. At the Gimbel Eye Centre in Calgary, all cataract surgery is conducted under regional anaesthesia, either retrobulbar or peribulbar block, and sedation is required in less than 1% of patients. Since 1984, all patients have been advised to have their normal breakfast, including solids if this is their habit, and medications on the morning of surgery. There is therefore no change in their daily routine. This is particularly appreciated and satisfactory for diabetic patients who account for approximately 12% of all our cataract patients. “Pure” regional blocks (without sedation) are also used at Foothills Hospital, where the same preoperative regimen was adopted in 1988. Our combined experience now extends to more than 30,000 patients, with no case of aspiration of gastric contents. This number includes 14 patients, eight of whom lost consciousness, in whom central spread of the local anaesthetica occurred [2]. No measurements of gastric fluid volume or pH have been made and the absence of complications does not mean that they cannot occur. Nevertheless, the statistical “rule of three” [3/n] means that the long-term incidence will not be greater than 3:30000 or 1:10000.

We emphasize that these patients do not have heavy sedation, and the regional block is not converted to a general anaesthetic. For this particular group of patients, we therefore recommend no preoperative fast and encourage full diet. In contrast, we do not endorse Professor Strunin’s recommendation of clear fluids only on the day of surgery.

J. R. MALTBY
R. C. HAMILTON
Foothills Hospital
Calgary

FASTING BEFORE ANAESTHESIA

Sir,—While interested in challenging unfounded dogma [1], we should not discard accepted practice until better methods are demonstrated. In addition, new ideas can easily be misconstrued.

According to our local newspaper [2], not only can you “win an op on the radio” through last-minute cancellations by other patients for operations on “such ailments as varicose veins, hernias and ingrowing toenails”, but Sidcup hospital advised that “as these patients will receive only a light anaesthetic, it shouldn’t matter if they have already eaten”!! This message was spread to more than 75000 people—the newspaper’s claimed distribution.

The two patients who died in Mendelson’s report [3] had ingested “full meals” 6 and 8h before anaesthesia: they died because of suffocation on the delivery table. I hope that history unlearnt is not relearnt.

C. LANIGAN
Medway Hospital
Gillingham

ANAESTHESIA FOR NASOTRACHEAL INTUBATION IN DENTISTRY

Sir,—Two papers in the same issue report success rates of 90% [1] and 83% [2] for nasotracheal intubation in dental practice using propofol and alfentanil. Alcock and colleagues [1] wished to avoid possible excessive cardiovascular depression with a larger dose of propofol and Coghlan, McDonald and Csepregi [2] did not wish to use topical local anaesthesia. I anaesthetize day-case patients using tracheal intubation in an isolated dental unit and wish to avoid myalgia and adverse reactions associated with the use of suxamethonium.

The publication by Guidon-Attali and colleagues [3] reporting 100% success using propofol 3.5 mg kg"1 and topical anaesthesia led me to change my practice. Adult patients requiring intubation are placed supine to prevent haemodynamic consequences; continuous monitoring of ECG, non-invasive arterial pressure and pulse oximetry are commenced and patients receive alfentanil 500 μg. Those scheduled to undergo multiple extractions are given an oral NSAID before anaesthesia.

Propofol 3.5 mg kg"1 is administered and at laryngoscopy the cords are sprayed with 10% lignocaine; a further bolus of up to 50 mg may be required to ensure successful intubation. Anaesthesia is maintained by spontaneous breathing of a mixture of nitrous oxide, oxygen and enflurane. Using this technique, successful intubation without either significant myalgia or response to intubation is the rule and recovery is not delayed.

A. P. J. LAKE
Ysbyty Glan Clwyd
Bodelwyddan, Wales