Sir,—We should like to report disadvantages to the new style (laminated) cover of BJA.

First, it is no longer possible to use the white band of the front cover for recording of progress, completed reading or pages/ references for storing.

Second, we feel sure that we are not the only anaesthetists who have neither the space nor the time for journals at work and who receive journals at home. One colleague admits to storing journals in the garage. (Is the new cover designed to be more waterproof?)

Where this journal is concerned, anaesthetists should tread lightly.

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CONTINUOUS SUBDURAL BLOCK

Sir,—The report of continuous subdural block by Collier, Gatt and Lockley [1] raises some issues about the management of a suspected subdural block. In many instances, the diagnosis is made with certainty only in retrospect, by radiological contrast studies, and there are few guidelines to help at the time of uncertainty when the differential diagnosis between intraarterial block or multicompartment block may not be clear. In such circumstances, many would apply the "if in doubt, take it out" maxim and possibly attempt either to repeat the extradural at another space or perform a subarachnoid block. If the code is given, the possible large volume of subdural local anaesthetic may cause neurological damage by compressing spinal nerve roots, blood vessels or the cord [2], repeating the extradural at an adjacent space may exacerbate such a compressive effect. As the subarachnoid contents may be displaced by subdural fluid [2], locating the subarachnoid block may be more difficult, or the height of block affected. Given appropriate monitoring, small volume continuous subdural analgesia may be applied safely, but perhaps with greater safety using single end-hole rather than multiple end-hole extradural catheters.

Unlike Dr Collier's patient, I found that prolonged postoperative analgesia was a feature with subdural fentanyl 50 ug in millilitres 607-614


COMPARISON OF TWO MEASUREMENTS

Sir,—I read with interest Dr Runcie's letter [1] concerning the article by Berridge which described the influence of cardiac output on the correlation between mixed venous and central venous oxygen saturation [2]. Dr Runcie correctly pointed out that the statistical analysis of the data should examine the difference between mixed venous and central venous oxygen saturation and not the correlation between them. However, as has been noted previously [3], the original Bland-Altman technique [4] is not invariably an appropriate method for comparing two measurements: it is intended to determine the agreement between two methods of clinical measurement of a variable, when neither of the methods is sufficiently accurate to be considered "gold standard". In this method, the difference between the measurements is plotted against the mean of the two measurements, the mean of the measurements (rather than one or other of the two) being used as the independent variable for two reasons:

(1) When both measurements are subject to an unknown error, the best estimate of the true value of the variable is the mean of the two measurements [4]. This is not likely to be the case with Berridge's data: the measured mixed venous oxygen saturation is almost certainly a better measure of the true mixed venous oxygen saturation than is the mean of the central venous and mixed venous saturations.

(2) It is a well known statistical phenomenon that, if the difference between two values is plotted against one or the other, the difference is related to each of them [4]. For example, the expected correlation coefficient between the difference between

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Sir,—Dr Rowbottom's letter has highlighted the dilemma facing clinicians in the Labour Ward when an apparently normal extradural block develops atypical spread. The differential diagnosis between an accidental subarachnoid or subdural block or a high extradural has often to be made rapidly, on purely clinical grounds without the benefit of radiology, and a decision made as to how to proceed in the provision of Labour Ward analgesia or Caesarean section anaesthesia.

In extreme examples, the course is obvious, as in the case of subdural block and cardiac arrest described by Rowbottom and colleagues [1]: Caesarean section was performed during (successful) resuscitation. In lesser cases, many would, as Rowbottom suggests, abandon regional techniques; however, we have found subdural blocks, when recognized, to be somewhat similar to subarachnoid blocks in being fairly predictable in their onset and spread, and injection of small doses of local anaesthetic (0.5-2 ml), with or without opioid, with careful monitoring usually provides safe and efficient analgesia or anaesthesia [2].

The alternative management in the case of Caesarean section is to opt for general anaesthesia, with its attendant risks, including severe bradycardia and even asystole in patients given suxamethonium in the presence of high sympathetic block. Furthermore, another cause for concern about combined techniques has been brought to our attention recently, after two cases of maternal deaths in our area. These resulted from anaphylactic reactions to suxamethonium in patients who had extradural blocks in place. Both patients were reported as being "extremely difficult to resuscitate". To resort to general anaesthesia in a patient with an atypical block may introduce new hazards that could have been avoided by careful "tailoring" of the block to the patient's needs.

Finally, we cannot agree that terminal eye catheters confer any greater degree of safety than lateral eye catheters and, indeed, they may be less so. We have just concluded a study comparing the two types, and recorded one case of intravascular injection, through a terminal eye catheter, despite repeated negative attempts at aspiration. The ability to allow easy aspiration of blood or CSF has always been claimed to be the main advantage of the terminal eye catheter [3].

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