and the cervical spine was in the "sniffling" position, we were encouraged by the case report regarding an awake patient. We have noted that the technique appears equally successful when the cervical spine is immobilized in a neutral position. Awake tracheal intubation in cases of cervical spine injury allows neurological assessment during and after the procedure and it is claimed, although without supporting data, that preservation of muscle tone may provide some protection. Further studies are required in this patient population, using the technique of cuff inflation to define success rates, amount of cervical spine movement and effects on patient outcome. Studies comparing this technique with others such as awake fibroptic intubation would also be of interest.

N. M. GAJRAJ
J. H. PENNANT
A. C. VAN ELSTRAETE
R. A. VICTORY
The University of Texas Southwestern Medical Centre Dallas, Texas

USE OF ALFENTANIL AND PROPOFOL FOR DIFFICULT TRACHEAL INTUBATION

Sir,—In the letter from Coghlan, McDonald and Csepregi [1], it was suggested that the use of alfentanil and propofol for tracheal intubation [2] may be useful for management of the difficult airway. We have had the opportunity to use this technique successfully for such a case.

A 25-yr-old female presented 5 days after extraction of her wisdom teeth under local anaesthetic. She had developed a large right parapharyngeal abscess which severely restricted mouth opening to a maximum of 1 cm between upper and lower incisors. We elected to induce anaesthesia with halothane in oxygen and perform nasotracheal intubation using a fibroptic laryngoscope. Unfortunately, because of the large parapharyngeal swelling and subsequent distorted anatomy, we were unsuccessful. Attempts were made at blind nasal intubation, but these were also unsuccessful because of the nasotracheal tube being deflected by the parapharyngeal swelling. Laryngoscopy was impossible under deep inhalation anaesthesia, as the mouth would still not open more than 1 cm.

We were able to maintain an airway while the patient was breathing spontaneously, but had difficulty ventilating the lungs using a face mask and hence were reluctant to use a neuromuscular blocker for fear of losing control of the airway. We therefore decided to use the combination of alfentanil and propofol, with the ability to antagonize the effects of the alfentanil rapidly using naloxone, if this should be necessary. We gave alfentanil 25 mg kg⁻¹ followed by propofol 1 mg kg⁻¹. This enabled us to open the mouth 2 cm and perform laryngoscopy. We were able to visualize the tip of the epiglottis and intubate the trachea with the aid of a bougie.

We feel that this is a useful alternative technique, when used by experienced operators, for managing a patient with a difficult airway.

P. F. MCDONALD
Stoke Mandeville Hospital
Aylesbury

The Queen's University of Belfast

Sir,—In the letter from Coghlan, McDonald and Csepregi [1], it was suggested that the use of alfentanil and propofol for tracheal intubation [2] may be useful for management of the difficult airway. We have had the opportunity to use this technique successfully for such a case.

A 25-yr-old female presented 5 days after extraction of her wisdom teeth under local anaesthetic. She had developed a large right parapharyngeal abscess which severely restricted mouth opening to a maximum of 1 cm between upper and lower incisors. We elected to induce anaesthesia with halothane in oxygen and perform nasotracheal intubation using a fibroptic laryngoscope. Unfortunately, because of the large parapharyngeal swelling and subsequent distorted anatomy, we were unsuccessful. Attempts were made at blind nasal intubation, but these were also unsuccessful because of the nasotracheal tube being deflected by the parapharyngeal swelling. Laryngoscopy was impossible under deep inhalation anaesthesia, as the mouth would still not open more than 1 cm.

We were able to maintain an airway while the patient was breathing spontaneously, but had difficulty ventilating the lungs using a face mask and hence were reluctant to use a neuromuscular blocker for fear of losing control of the airway. We therefore decided to use the combination of alfentanil and propofol, with the ability to antagonize the effects of the alfentanil rapidly using naloxone, if this should be necessary. We gave alfentanil 25 mg kg⁻¹ followed by propofol 1 mg kg⁻¹. This enabled us to open the mouth 2 cm and perform laryngoscopy. We were able to visualize the tip of the epiglottis and intubate the trachea with the aid of a bougie.

We feel that this is a useful alternative technique, when used by experienced operators, for managing a patient with a difficult airway.

P. F. MCDONALD
Stoke Mandeville Hospital
Aylesbury

THE P < 0.05 CRITERION IS NOT INVIOBLE

Sir,—It is interesting to read that single stimuli every 10 s and train-of-four stimulation every 10 s yield different estimations of the potency of mivacurium. Maddineni and colleagues [1] reported that the leading twitch (T1) of the train-of-four exhibited a deeper block than the single twitch (T). The authors suggested, plausibly, that the more intense train-of-four stimulation itself and the secondary improvement in blood flow to the muscle hasten the onset and deepen block of T1. Another factor likely to contribute to the deeper block of T1 is that a train-of-four every 10 s allows less rest between stimulations (8.5 s to 10 s).

I wish also to comment on the authors' conclusion that T differs from T1 significantly for ED₅₀ (43 ± 35 mg kg⁻¹ (P = 0.003), insignificantly for ED₃₀ (83 ± 66 mg kg⁻¹ (P = 0.051)), and insignificantly for slopes of the dose-response curves. It is not logical that there should be a difference in only one of the two points of the regression lines without a difference in the slope.

Many authors and reviewers inflexibly adopt the customary "P < 0.05" criterion. Some even object to the notation of P = 0.01, P = 0.1, etc. and insist that either "P < 0.05" or "INS", and nothing else, be printed. Some further equate "statistically not significant" with "not different".

Others—a minority to which I belong—are more wary of the danger of type II error associated with small sample size in a highly variable population [2]. They point out that the P < 0.05 criterion is artificial. Borderline P values should be reserved [1, 2]. "Statistically not significant" is not "not different". If the means are not different, t tests rarely need to be done.

Taking the example of Maddineni and colleagues' study, great individual variability in data existed, as expected. Instead of describing P = 0.051 as insignificant but P = 0.03 significant, I would call both comparisons significant to P < 0.075. This leaves a 92.5% chance that the two differences in ED values are both significant, and allows the logical conclusion that the two regression lines are parallel. In other words, I would reject the P < 0.05 criterion. The authors' overall conclusion was in favour of the difference.

C. Lee
Harbor-UCLA Medical Center Torrance, California

Sir,—I agree entirely with the sentiments expressed by Dr Lee. He has obviously noted that the difference between the ED₃₀ values was also very close to being significant (P = 0.051). This was the aim of our giving the actual P value rather than simply saying that the difference was insignificant.

We are glad to see that Dr Lee agrees with the conclusions we had reached and I hope others will reach similar conclusions. I also agree with him that to describe a difference as significant at P < 0.05 is only arbitrary, although conventional.

R. K. MIRAKHUR
The Queen's University of Belfast

SPINAL NEEDLE: AN UNUSUAL COMPLICATION

Sir,—We read with interest the report on "Concorde nose" in Whitacre spinal needles in which McLeod, Carson and Bannister illustrated the point that, if a Whitacre needle strikes bone, the needle should be removed and discarded [1]. The side hole in a pencil-point needle renders it weak and thus makes it more prone to bending. We recently encountered bizarre bending of the stilette of a bevelled re-usable spinal needle, presumably after striking bone.

A 37-yr-old ASA I female was to undergo vaginal hysterectomy under spinal anaesthesia. A 23-gauge bevel-tipped spinal needle was introduced slowly at the L₃-₄ interspace with the patient in the left lateral position. Resistance was felt at a depth of about 4 cm and, on the presumption that the needle had entered the ligament flavum, a slight increase in force was made. After some resistance, the needle moved in with a jerk. Believing that the needle had by then entered the subarachnoid space, the resident attempted to remove the needle under duress, but could not. On a second attempt, the hub sheared off at the junction with the shaft, which stayed inside the needle. An attempt was then made to withdraw the needle and the stilette together, but although the needle was removed, the stilette (without hub) remained in situ. By increasing the flexion of the spine, it was possible eventually to remove the stilette, using some force. After removal, the tip was found to be...