and sore throat that developed after general anaesthesia for minor gynaecological surgery, of less than 10 min duration, in almost 900 patients who had given informed consent [2]. Patients were allocated randomly to two groups. One group received suxamethonium 1 mg kg$^{-1}$ after induction of anaesthesia and underwent manual ventilation of the lungs with nitrous oxide via face mask. The other group breathed nitrous oxide spontaneously and anaesthesia was maintained with increments of the chosen induction agent. Tracheal tubes were not used and Guedel airways inserted only in a small number of patients (4%) with difficult airways; these were excluded from further analysis.

Whilst the overall incidence of suxamethonium pains in 407 patients was found to be 52%, the incidence of sore throat in this group was 19%, compared with 3.2% in the non-paralysed group ($P > 0.001$). In 81% of the patients with sore throat following suxamethonium, typical muscle pains also developed, usually involving neck pain or stiffness as a major component (85%). It is difficult to attribute the sore throat to any other factor, unless the brief period of intermittent positive pressure ventilation exerted some effect on the pharynx or larynx.

Thus it does appear as if sore throat is another manifestation of suxamethonium pains, presumably because of action of the agent on the muscle spindles of the laryngeal or pharyngeal muscles, although this has not been demonstrated [2]. As Deacock pointed out [1], suxamethonium must be taken into account when postoperative sore throat is assessed and this depolarizing agent has been used.

C. B. COLLIER
Royal Hospital for Women
Sydney
Australia


POSTDURAL PUNCTURE HEADACHE AND EXTRADURAL BLOOD PATCH

Sir,—We read with interest the editorial on the use of extradural blood patches in dural puncture headache [1]. We have recently treated a 47-yr-old lady who presented to the neurologists with a 6-week history of headache secondary to a spontaneous dural leak of CSF.

This cause of headache is very rare, with only a small number of case reports in neurological journals [2]. The signs and symptoms are identical to those found in patients with dural punctures who are seen by anaesthetists. Investigation of this lady by the neurologists demonstrated a collapsed ventricular system on CAT scan, with decreased CSF pressure and caudal extension of dye on the myelogram. It was thought that the defect in the dura was probably in the lumbar region, so we performed a lumbar extradural blood patch. This produced some relief within 15 min, and by the next day she was able to go home.

Previous case reports have described conservative treatment [3], with blood patch used as a last resort [4]. This case adds further evidence to the signs and symptoms of dural puncture headache being secondary to decreased CSF pressure.

S. HARROD
J. M. G. FOSTER
St Bartholomew’s Hospital
London