CORRESPONDENCE

Anaesthesia datasets

Sir,—While I agree with the need for a minimum dataset for anaesthetic logbooks, particularly in light of the forthcoming changes in training, I am a little perturbed by the inclusion of names and dates of birth of patients.

Drs Lack, Stuart-Taylor and Tecklenburg [1] describe a minimum dataset for anaesthetic logbooks. In the data fields described, the name and the date of birth of patients are included. No distinction was made as to whether the ("electronic") logbooks were to be held on "home" computers or on "hospital" machines. According to the Data Protection Act of 1984 [2], records of the type described above living, identifiable individuals, place obligations on those who record and use personal data. The users must be open about this use through the Data Protection Register. The Act does not cover information that is held and processed manually (ordinary paper files), and there are other exemptions, but many data users may find that as they cannot rely safely on the exemptions, they will need to register under the Act.

While departmental logbooks would be covered by registration of the hospital, individual logbooks on personal computers would not.

A. TWIST
Department of Anaesthesia
Royal Victoria Infirmary
Newcastle upon Tyne


Sir,—I am sorry that our article was not clear enough; the dataset referred to is for anaesthetic records of any type, not just logbooks.

I entirely agree on the subject of inclusion of personal identifiers in records; it is a very difficult topic. Clearly, any record of anaesthesia has to contain personal identifiers, and it is difficult to see precisely when, in the process of aggregation to produce reports and statistics, one should remove them. On the one hand there is a very understandable wish for a clinician to be able to review all the records of any particular recorded complication, but on the other hand, clinicians might take a very different view about recording complications if the reviewer were a lawyer!

The Royal College has set up a working party under the chairmanship of Professor Adams to discuss the content of both the anaesthetic record and the logbook, and it will report in due course. The minimum dataset (which we wrote about for records) and the recommended content of both (which has yet to be decided) are different.

Logbooks are a required part of training, but their value has been discussed unendingly. College visitors reviewing paper logbooks frequently find them almost worthless, containing much data but little information. Statistics from paper records are logbooks almost worthless, containing much data but little information. Statistics from paper records are nonexistent, but the content of the record will not necessarily be different, and our discussions are not centred around this issue, but rather what it is reasonable to require in a recording. Your correspondent's comments about the Data Protection Act are both true and helpful, and we shall take them into account when we reach that stage.

J. A. LACK
Anaesthetist Department
Salisbury Hospital
Salisbury

Acid aspiration syndrome in obstetrics

Sir,—The editorial on the latest Confidential Enquiry into Maternal Deaths raised the question of whether or not prophylactic antacid therapy during labour should be restricted to only those women deemed to be "at risk" [1]. Although it is not possible to prove a causal relationship, there has been a decrease in the incidence of fatal obstetric acid aspiration syndrome during the past 10 yr in parallel with the increased prophylactic use of H₂ receptor blocker drugs in labour [2]. Undoubtedly, improved training and increased use of regional anaesthetic techniques have contributed significantly, but we believe that the value of routine use of ranitidine in labour should not be underestimated.

Sodium citrate alone, as a single perioperative dose, or multiple doses during labour, failed to reliably increase intragastric pH above 3 [3]. However, pH values greater than 3 were achieved with regular 6-hourly oral ranitidine, commenced at the onset of established labour and then combined with a perioperative dose of sodium citrate [3].

Several obstetric units have adopted the policy of targeting ranitidine prophylaxis at high-risk patients (rather than pre-

Risk of aspiration with the laryngeal mask

Sir,—In their recent article relating to regurgitation and aspiration with the laryngeal mask airway [1], Akhtar and Street made no prediction of the expected incidence of regurgitation or aspiration, despite the availability of such data from previous studies, nor did they state the magnitude of a difference between the two groups which they would consider clinically important. Thus they seem to have made no calculation of the sample size necessary to measure the incidence with confidence or to detect a statistically significant difference between their ventilated and spontaneously breathing groups. The incidence which they reported was 4%. However, in a sample size of 50, the 95% confidence intervals are 0.49 to 13.71% (Geigy Scientific Tables; exact confidence limits).

The authors stated correctly that they found no statistically significant difference in the incidence of regurgitation between patients breathing spontaneously or undergoing ventilation via an LMA. Their data do not show a statistically significant difference in the incidence of aspiration. I have estimated the sample size necessary to show a difference in incidence of 1% from the previous greatest incidence of 0.8% quoted by them [2]. The sample size needed to show a difference of 4% would be approximately 350.

Although the sample used is clearly too small to achieve the authors' aims, the finding that in the patient who regurgitated, the fluid was dispersed into the bronchial tree is interesting and may merit further investigation.

COILIN OHAISEADHA
Department of Anaesthesia
University Hospital Nottingham
Nottingham


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