Correspondence

Sir,—We are grateful for the opportunity to reply to the letter from Drs Jones and Nixon, comparing the results of their audit of postoperative extradural analgesia with our own published results.

It would appear from the results of Dr Jones and colleagues that the use of extradural fentanyl–bupivacaine mixture was associated with less hypotension and better pain relief than the diamorphine–bupivacaine mixture used in our audit. However, comparisons based on audit data from different institutions are difficult and we would like to make the following points: (1) the majority of our patients were more than 60 yr of age and were recovering from major upper abdominal surgery, thoracic surgery or chest trauma. There are no details on the case mix of Dr Jones’ patients; (2) our audit included data from our learning curve while setting up the service, whereas the group from Gwent ran a series of pilot studies and studied their definitive regimen.

Nevertheless, we would totally support their recommendations that extradural infusion analgesia can be managed in a general ward setting, under the supervision of an acute pain team, and that further research is necessary to determine the most appropriate opioid to use in combination with local anaesthetic drugs for extradural analgesia.

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Neuromuscular block and tourniquets

Sir,—The problem with atracurium degradation in an isolated limb [1] has been noted before [2]. However, in the course of a study [3] of the effects of adding atracurium to a Bier’s block (atracurium 2 mg in 0.5% prilocaine 40 ml), we showed that motor paralysis was always prolonged beyond the time of tourniquet deflation, in one case for nearly 1 h after a tourniquet time of 47 min.

It is difficult to explain the difference, although it may lie in our use of an Esmarch bandage to achieve maximal exsanguination. However, this does point the way to a reliable technique for paralysing an isolated limb, even with atracurium.

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Spinal anaesthesia and aspirin

