Correspondence

Unfractionated heparin and coronary artery stenting

Editor—We read with interest Vicenzi and colleagues' paper concerning coronary artery stenting and non-cardiac surgery. We were concerned by the high cardiac complication rate they reported, particularly in patients receiving unfractionated heparin (UFH) as a component of their anticoagulant regime (14 patients out of 16) compared with low molecular weight heparin (LMWH) (32 out of 87). The authors, while noting this association, warn against interpreting this as a significant effect, as the heparin regime was not subject to randomization in the study design. We believe, however, that this is further evidence of 'heparin rebound'—a period of hypercoagulability after abrupt cessation of an infusion of UFH. This can be associated with ischaemic events when UFH is used in the management of unstable angina and myocardial infarction. This effect has been attributed to an increase in thrombin activity and activation of platelets during UFH infusion which persist for many hours after cessation of infusion, whilst the protective anticoagulant effects decline rapidly because of the short half-life of UFH. Ischaemic events in Theroux and colleagues' study were clustered around a median time of 9.5 h after cessation of UFH. Ischaemic events in Theroux and colleagues' study ischaemic events and should, perhaps, be considered the drug of choice in this setting.

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Adverse events in anaesthetic practice

Editor—I read with interest the article by Smith and colleagues on adverse events in anaesthetic practice. I have recently completed an audit in our anaesthetic department to ascertain the reason why critical incidents are under-reported. My audit relied on both consultants and registrars completing an anonymous questionnaire, the results of which are summarized in Table 1. I was pleasantly surprised to see that we are overcoming the era of ‘blame culture’ and that triviality was the most common reason for under-reporting. I, as do some of my colleagues anaesthetists, agree that the definition of ‘criticality’ is ambiguous. As a result most of us would not regard situations such as laryngospasm and circuit disconnection as a ‘critical’ incident. Anaesthesia as a speciality is fraught with life-threatening