disease process with serovar. Patients infected with *Icterohaemorrhagiae* progressed rapidly to multi-organ failure as reflected by this case report.

The patient described had all the classical features of leptospirosis and responded well to therapy initiated in a timely fashion and aggressive organ support. Hence the appropriate title for the report should be ‘Acute lung injury and multi-organ dysfunction; Usual manifestation of unusual leptospirosis in United Kingdom’.

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Editor—We thank Dr Ramachandran for his comments and welcome the opportunity to reply. We agree that pulmonary manifestations occur in 20-70% of patients with leptospirosis, but most of them resolve without any sequelae. Very few progress to severe forms such as pulmonary haemorrhage and ARDS associated with very high mortality. Carvalho and Bethlem commented that ‘the severe form appears to be becoming more prevalent (at least in Brazil) and may be associated with higher mortality’, they have not categorically stated that fatal pulmonary manifestations is a usual finding universally. Further, the study of autopsy findings in 62 cases of Leptospirosis revealed pulmonary haemorrhages in 48 (77%) of patients. We would like to emphasize the fact that this is an autopsy finding and without the background information of the prevalence of the disease, it would be difficult to comment on the incidence of pulmonary and other organ involvement. Hence, we feel that the title is an appropriate one. However, since leptospirosis is a worldwide zoonosis with protean manifestation, the incidence of complications varies widely in different epidemiological regions. It would be very difficult to estimate the exact incidence of complications, hence the need for high index of clinical suspicion to diagnose and initiate early treatment for this potentially lethal disease.

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Comparison of patient-controlled epidural infusion with nurse-administered epidural infusion

Editor—I read with interest the study comparing patient-controlled epidural infusion with nurse-administered epidural infusion for patients undergoing colonic resection. The authors correctly identify that the four-point verbal rating scale (VRS) used to assess postoperative pain would produce non-parametric or qualitative ordinal data and used the Mann–Whitney *U*-test for statistical analysis. The authors also describe the mean and standard deviation for the VRS scores which are parametric statistics and not appropriate for these data. Instead, the median and inter-quartile range should be used to describe the central tendency and spread of non-parametric data. The conclusion that mean summary pain scores are significantly lower in the patient controlled epidural analgesia (PCEA) group is therefore inaccurate. The Visual Analogue Scale, which utilizes a 100 mm continuous scale to assess pain, could be described as quantitative, ratio data and may be more appropriate for parametric analysis.

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Editor—Thank you for the opportunity to respond to Dr Chambers’ comments. As clearly indicated in the text and stated in the results section, median scores were reported and compared using a Mann–Whitney *U*-test. We feel that he may be confused by the fact that the ‘mean’ score of repeated measurements per patient was used as one of the outcome measures and thus formed the unit of measurement, and not the summary statistic for comparison. More precise wording may have helped, stating that the median of the mean scores per patient was found to be significantly lower in the PCEA group.

Dr Chambers also feels that presenting means and standard deviations is inappropriate. We disagree on three counts. First, means and standard deviations are often used to inform sample size calculations, even in situations in which non-parametric tests are thought to be necessary. We felt that publishing these figures might help others in the quest to design studies where the same measurement tool is used. Secondly, means and standard deviations are
more easily combined through meta-analyses to provide evidence from several studies in systematic reviews. Finally, this study might be considered sufficiently large to justify the use of parametric tests to compare the summary outcome measures.

The Visual Analogue Scale was not employed in this study and therefore parametric analysis was not employed.

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**Role of dantrolene in the management of the acute toxic effects of Ecstasy (MDMA)***

Editor—The use of dantrolene in the management of hyperthermia for acute ‘Ecstasy’ (3,4-methylenedioxyamphetamine, MDMA) toxicity has been recently reviewed by Hall and Hendry.1 We would like to confirm the efficacy of dantrolene after a recent case that presented to our emergency department.

A 21-yr-old male presented after collapse with, GCS 4/15, generalized rigidity, tachycardia (160 min⁻¹), hypertension (170/120 mm Hg), tachypnoea (40 min⁻¹), and hyperthermia 41.7°C. The history confirmed Ecstasy ingestion. Initial treatment involved physical methods to cool the patient, such as cold i.v. fluids and ice packs. Diazepam 10 mg i.v. and acetaminophen 1 g p.r. were administered. For the following 45 min, the patient’s clinical state failed to improve. After this time, the anaesthetist present gave 1 mg kg⁻¹ dantrolene and almost immediately the patient’s rigidity reduced. Serial measurement of body temperature after dantrolene administration revealed a reduction in core temperature to 38.7 after 30 min and this continued to decrease until it was within normal limits at 90 min. The patient was subsequently transferred to ITU where he was treated supportively for 4 days. He was then discharged to the ward having made a full recovery.

We concur with the recommendation that dantrolene is an effective treatment for hyperthermia due to MDMA ingestion. Its early use in our case appears to have been instrumental in controlling this patient’s hyperthermia.

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**Fastrach™ tubes: modifying the design for use with the LMA CTrach™?**

Editor—I would like to congratulate Liu and colleagues1,2 and Timmermann and colleagues3 on their informative articles critically analysing the LMA CTrach™. I would like to point out that despite the significant improvements of the CTrach™ over the LMA Fastrach™, especially in the ability to observe the tracheal tube passing through the glottis, the manufacturer seems to have failed to make appropriate changes to the design of the Fastrach™ tracheal tubes. In particular, the Fastrach™ tube has no markings to assist the operator performing the intubation to correctly position the tracheal tube below the glottis. The majority of tracheal tubes currently available have either one or two black lines as intubating guides approximately 2–3 cm proximal to the tracheal tube cuff. These marks should be placed at the level of the glottis to avoid both endobronchial intubation and the tracheal tube cuff being too close to the glottis where it may cause inadvertent damage or partial extubation. The importance of these intubation guides was reviewed in a recent paper.4

To assess the importance of intubation marks on the insertion of a Fastrach™ tracheal tube, I have taken two figures from the LCD viewer of the CTrach™ while intubating a manikin. Figure 1 shows the tracheal tube without a mark passing through the glottis. In comparison, Figure 2 shows the same tube with an intubation guide mark drawn with a permanent marker at 3 cm proximal to the tracheal tube cuff. This mark assists an operator placing the tracheal tube to an appropriate depth within

![Fig 1 Fastrach™ tube without intubation guide mark.](https://example.com/fastrach.png)