Despite 30 yr of using thoracic epidural analgesia, this still remains an inexact science. Large surveys still show high failure rates, and this seems unlikely to change. It has to work in the real world of limited resources, variable operator skill, and stretched services. I cannot see the anaesthetic community having much appetite for another large study to prove that thoracic epidurals are safe. We are going to have to use less than optimal data and a degree of common sense to decide how best to move forward. The use of thoracic epidurals outside of a critical care environment should be performed with caution, if at all. If epidurals are not working, they need to be rapidly improved, resited, or removed. Many epidurals are left in situ despite less than optimal analgesia. Considering that the epidural may significantly increase the patient’s cardiovascular risk, persisting with a suboptimal epidural would seem very unwise.

Declaration of interest
None declared.

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5 Ballantyne JC, McKenna JM, Ryder E. Epidural analgesia-experience of 5628 patients in a large teaching hospital derived audit. Acute Pain 2003; 4: 89–97

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No more colloid trials!

Editor—In regione caecorum rex est luscus (In the land of the blind the one-eyed man is king)

We read Friedman and colleagues’ recent article with interest, and agree that the introduction of video analysis is an important addition to the educational process. We have evaluated the complete process of central neuraxial block using the technique described below. Our initial set-up also involved a camera and tripod, but this was found to be rather intrusive, by both patients and trainee anaesthetists, particularly in the already busy obstetric theatre.

It is well recognized that junior doctor training has undergone significant changes over recent years, with the limited working hours imposed by the European working time directive. There has been a shift towards service provision, and training haemodynamic resuscitation: ‘When titrated to physiological end points, even large volumes of balanced salt solutions are tolerated well’. The homeostasis of extracellular fluid distribution between the circulation and the interstitium depends on the neurohumoral regulation of capillary pressure and the effective surface area for filtration. As I have previously argued in this journal, recent physiology discoveries explain why there is no good reason to prefer a resuscitation solution containing starch or gelatin while capillary pressure is lower than the J point. In my view, it is time to investigate truly pharmacological approaches to optimizing colloid resuscitation and to consign biophysical therapy with plasma substitutes to historic footnotes.

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Point-of-view high-definition video assessment: the future of technical skills training

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