symptoms. The anatomy is variably described and possibly poorly understood, briefly it contains three anatomically distinct fascial compartments surrounded by fibrous fascia and all overlying the ilium; the maximus compartment, the minimus compartment, and the tensor compartment. The sciatic nerve lies deep to the maximus compartment and may be compressed against the ilium during compartment syndrome.

This patient developed gluteal compartment syndrome due to the combination of length of surgery and morbid obesity, there was no evidence of any iatrogenic trauma to the right buttock or its vascular supply. We believe that this case is unusual, in that the symptoms of paralysis and sensory loss were out of proportion to the initially mild buttock pain which led to the investigation of epidural haematoma delaying definitive diagnosis and surgical treatment. We are uncertain of the contribution of the epidural infusion to the level of pain at presentation; however, the infusion had been stopped for around 6 h before the first examination.

There are three important points raised by this case. First, this reinforces the view that the complications of prolonged immobility in obese patients are potentially limb threatening, positioning of these patients should be meticulous. Secondly, gluteal compartment syndrome can mimic epidural haematoma. The similarities would have been more pronounced and confusing had the compartment syndrome been bilateral, which has been previously reported. Thirdly, we should question any diagnosis which does not account for all of a patient’s symptoms. This initial hip pain was mild and was neglected but was key to making the diagnosis. This concept is better expressed as Occam’s razor which encourages doctors to look for the fewest possible causes that will account for all of the symptoms.

Conflict of interest
None declared.

R. O’Leary
B. McAree
M. D. D. Bell
M. Troxler
P. Jackson*
Leeds, UK
*E-mail: phil.jackson@leedsth.nhs.uk

Correspondence

Cricoid force in children

Editor—I read with great interest the article by Walker and colleagues describing compression of the subglottic airway during application of cricoid pressure in children. The findings suggest that possibly related to specific airway morphology and anatomy, children may be even more susceptible than adults to the distorting effect of cricoid pressure on airway anatomy.

In this context, it may be of interest that a couple of years ago, the Section on Paediatric Anaesthesia of the German Society of Anaesthesia and Intensive Care Medicine (DGAI) issued a recommendation on rapid sequence induction in children. Considering the known side-effects of cricoid pressure (e.g. interference with airway management, more difficult laryngoscopy and intubation, provocation of retching and vomiting) and the lack of demonstrated benefit of cricoid pressure in general, application of cricoid pressure is officially no longer advocated in children. The findings (not published yet) of our recently finished web-based questionnaire of German anaesthetists strongly suggest that in Germany, this recommendation is already translated into routine clinical practice. Of 3098 anaesthetists replying to the questionnaire, only 1.1% use cricoid pressure in children below the age of 8 yr. The study by Walker and colleagues provides further reason for discontinuing a practice of unproven clinical benefit.

Conflict of interest
None declared.

H.-J. Priebe*
Freiburg, Germany
*E-mail: hans-joachim.priebe@uniklinik-freiburg.de

doi:10.1093/bja/aeq047

doi:10.1093/bja/aeq048