and is a cause of patient dissatisfaction. Laryngoscopy and tracheal intubation can cause injury to the pharyngeal mucosa which results in inflammation leading to POST. The use of smaller tracheal tubes, supraglottic devices, careful instrumentation of the airway, gentle suction of the oropharynx, water-soluble jelly on the tracheal tube, lower intracuff pressure, gargles, etc. have been used to reduce the incidence of POST.

It is known that N-methyl-D-aspartate (NMDA) has a role in nociception and inflammation. NMDA receptors are found in peripheral nerves and in the central nervous system. Hence NMDA antagonists such as ketamine work on peripheral nerve endings in pharyngeal mucosa and can decrease the incidence of sore throat. Magnesium is an antagonist of the NMDA receptor ion channel and it is available as powder, paste, or solution. We evaluated the efficacy of nebulized magnesium sulphate for attenuating POST. Forty adult patients, ASA I or II, of either sex, undergoing elective open cholecystectomy were randomized in two groups. Group C received 3 ml saline nebulization and Group M received 3 ml (225 mg) of isotonic magnesium sulphate nebulization for 15 min, 5 min before induction of anaesthesia. We assessed the incidence and severity of POST at rest and on swallowing and side-effects at 0, 2, 4, and 24 h in the postoperative period. The incidence and severity of POST was found to be reduced at rest and on swallowing for all time points (P < 0.05).

We chose nebulization over a gargle as it can be used in unconscious patients and children. We conclude that nebulization with magnesium sulphate before induction of anaesthesia is an effective method for decreasing incidence of POST.

**Declaration of interest**

None declared.

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**Is age a predictor of mortality in a UK medical high dependency unit?**

Editor—I welcomed the recent study on mortality in a UK high dependency unit. I particularly enjoyed the editor’s key points which I repeat here:

- Age does not predict the outcome from a medical high dependency unit in the UK.
- More than two organ support and pre-admission moderate/nursing home care are associated with worse outcome.
- Selected elderly patients should not be denied higher levels of care.

The editor’s second point is a useful guide to point out to my medical colleagues and fellow anaesthetists, who have limited interest in critical care. Also, most importantly, these points help those of us practicing in the District General Hospitals manage our meagre resources efficiently. For the sake of completeness and without blinding us again with statistics—the sample size is small—100. I have been in critical care a little more than 10 yr and I cannot agree more with the editor’s summary.

**Declaration of interest**

None declared.

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**Reply from the authors**

Editor—we thank Dr Adegoke for his comments on our paper. The arguments we make are likely to become only more relevant as the pressure placed on critical care resources increases with the combination of an ageing population in an economic downturn. We recognize that the sample size is relatively small, although this does represent a prospective series in which significant findings were obtained from a pre-planned analysis. Medical high dependency units represent an under-researched area which has unique patient cohorts and requirements. Further work is needed to better define the outcomes for these patients,
which will help clinicians decide best who to admit to these units and also will give prospective prognostic information to patients themselves. Larger cohorts are needed, which may well be best derived from either nationally collected databases or the results of trials work in this setting.

**Declaration of interest**

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