80-90 mm Hg, to give good operative conditions. It is not clear what statistical evidence or what quantity and quality of clinical data support the surprising, optimistic and bold words “without risk”. The time factor has not even been considered.

I suspect few anaesthetists would care to be subjected to a systolic pressure of 60 mm Hg, without very good reason!

BARBARA COLLIER
London

Sir,—Dr Collier is disappointed that we did not comment on e.g. changes during hypotension. Alas, we cannot remedy this because no such changes occurred. A continuous recording was taken in each case and none showed any arrhythmia.

If she has evidence that changes in rhythm during hypotension indicate cardiac hypoxia and a low cardiac output (and “considered by some” hardly rates as evidence), then she should publish it. The only relevant reference is a very old one, Rollason and Hough (1960). If making measured the cardiac output, which is after all the most important single parameter of the circulation, and found it is little affected by hypotension, then one is encouraged in the belief that the method is relatively safe because tissue hypoxia is unlikely to occur when total blood flow is adequate.

Our view that controlled hypotension is a safe procedure is based, not on ten patients, but on twenty-five years experience of the technique in this centre. Others, we know, have had similar results. Dr Collier’s methods of producing a bloodless field are doubtless admirable in her hands. She must not, however, imagine that alternative methods are harmful to patients, and can be proved to be so if only the right tests are done. If she has evidence, we say again, let her produce it.

Finally, we can assure her that the writers would certainly be willing to have our systolic pressures reduced to 60 mm Hg if the operative procedure warranted it. We assume that the anaesthetist would be competently trained in the method and have enough knowledge of the circulation to eschew irrelevant e.g. changes and ideas about arbitrary levels of “unsafe” systolic pressure.

D. B. SCOTT, G. W. STEPHEN, R. L. MARSHALL
J. L. JENKINSON, W. R. MACRAE

REFERENCE

BLIND NASAL INTUBATION WITH PROPA NADID
Sir,—I would be grateful for space to disagree most emphatically with the views expressed by Dr J. A. H. Davies in his article “Blind Nasal Intubation with Propa n adid” (Brit. J. Anaesth., 1972, 44, 528).

I see no indication whatsoever for teaching the use of intravenous induction agents which can cause respiratory arrest for patients who, in the event, are potentially impossible to intubate. An e.g. record would have been useful in his series and the success rate determined for the second group, for which intravenous induction agents are used. Our view that controlled hypotension is a safe procedure is based on the second group, for which intravenous induction agents are used, and agree that an e.g. would have been valuable though inadequate by itself to demonstrate important physiological disturbances. A future study might with value compare the available techniques in this respect bearing in mind that e.g. irregularities are common after intubation by the oral route.

I agree that the position of the head should be related to the curvature of the tube and must apologize for not reporting in my article that I rejected tubes with pronounced curves or those which were unduly straight. I accept that “sniffing the morning air” position may not be the best position for the head but unless the best position differs in the methods I used, which is unlikely, my comparison of the two methods remains valid.

No doubt the success rate of junior anaesthetists before being taught will be low but I see no reason why it should not exceed the success rate I have documented if they are given the opportunity for learning the techniques on routine cases. I fail to see why “few junior anaesthetists” are highlighted in parentheses but this will serve a worthwhile purpose if it emphasizes the fact that one anaesthetist can teach a few, whereas many need to learn.

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