


THE POSTERIOR INTERCOSTAL SPACE

Sir,—Drs Nunn and Slavin (1980) should be congratulated on their excellent study of the anatomy of the posterior intercostal space. However, we feel that their recommendation that the intercostal nerves be injected posteriorly 7 cm from the midline may present two problems. First, in the typical obese patient undergoing cholecystectomy the ribs are felt better more laterally. Second, there have been reports (Benumof and Semenza, 1975; Brodsky and Mark, 1979) of intercostal blocks inserted during operation which have resulted in hypotension consistent with spinal or extradural spread of the local anaesthetic agents. These blocks are generally performed under direct vision at the angle of the rib or more medially.

We therefore recommend (Cronin and Davies 1976) that posterior intercostal blocks are performed about 15 cm from the midline to minimize the possibility of spinal or extradural spread and to ensure that the rib is easily felt to reduce the chance of pneumothorax.

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REFERENCES


HALOTHANE AND OXYGEN ELECTRODES

Sir,—It was stated in a recent article that the effect of halothane on oxygen microelectrodes was reversible only slowly (Maekawa, Okuda and McDowall, 1980). However, the relationship between the time constant of the halothane effect and that of its reversal is unclear. It would be helpful to know the time intervals between exposures in order to qualify the term "slowly". While clarification of the reversal time constant may be of limited significance in the context of bench-type oxygen electrodes, it assumes greater importance when transcutaneous electrodes are considered.

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REFERENCES


SIR,—It was not our purpose to study the reversal of the effect of halothane on the oxygen electrode and therefore we cannot give a quantitative reply to Dr Rafferty's question.

The high sensitivity to halothane was present again next morning, so we can confidently state that the halothane effect was reversed within 18 h. During the working day there was no sign of reversal and some of the tests were separated by 2 h.

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DOSE OF ICI 35 868

Sir,—Rogers and colleagues (1980), in their preliminary investigation of ICI 35 868 1 mg kg⁻¹ i.v., failed to induce anaesthesia, contrary to our previous experience (Kay and Rolly, 1977). The onset and duration of sleep induced by this agent is affected by many factors, including premedication, apprehension (which may be increased by extensive monitoring), and especially by rate of injection.

Adam, Glen and Hoyle (1980) showed that, in animals, the half-life of the distribution phase of ICI 35 868 is very short, and this has subsequently been confirmed in man. To induce sleep, the rate of administration must be rapid enough to achieve the brain concentration required in the particular patient and circumstances, allowing for extremely rapid redistribution to other parts of the body. Thus, rate of administration is almost as important as total dosage, and it seems appropriate to use a much shorter injection time than 30 s for clinical use. Even variations in the rate of injection to more than 30 s can affect the onset and duration of sleep produced by a single dose.

ICI 35 868 1 mg kg⁻¹ injected over 20 s invariably induced sleep in healthy young unpremedicated patients, and ICI 35 868 and methohexitone were equipotent at a dose of approximately 1.5 mg kg⁻¹ (Kay, 1980). It would be unfortunate if unnecessarily large doses of ICI 35 868 became established as a "standard" induction dose.

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REFERENCES


