variation. Furthermore, because of the existence of those late peaks, we stated in our paper that the processing of the pharmacokinetic data was made on the mean curve; such a method induces some degree of inaccuracy in the calculated parameters.

To sum up, we feel that the assessment of the half-life of elimination of phenoperidine can only be approximate, more as a result of a large individual variability and a possible increase in the plasma concentration during the elimination period, than for chemical reasons (radioimmunoassay method). The wide individual variability had already been emphasized by Chan and colleagues (1983).

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REFERENCES

NASOTRACHEAL INTUBATION
Sir,—I congratulate Drs Willatts and Cochrane (1985) on drawing our attention to paranasal sinusitis—a complication of nasotracheal intubation which may be more common than presently appreciated, especially when mild.

In 1984, 20 victims of trauma involving head, chest and long bone fractures were ventilated in our intensive care unit. Nasotracheal intubation was used in all for periods of up to 10 days. One case of severe paranasal sinusitis was diagnosed when the patient, who was pyrexial for an undiscovered reason, began to produce purulent fluid on pharyngeal suction. The diagnosis was confirmed radiologically. Extubation and appropriate antibiotics produced a cure.

Another patient complained of headache, nasal obstruction and maxillary soreness on the side of a previous nasotracheal intubation. Sinusitis was diagnosed clinically and resolved with antibiotics and time.

We now look for this complication in all patients in whom nasotracheal intubation is used in the intensive care unit, especially if an unexplained pyrexia exists. We are reluctant to use the technique when fractures of the skull involve the paranasal sinuses, where there may be an increased risk of an infected haematoma leading to septicaemia or meningitis.

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REFERENCE

EXPERIENCE WITH NITROBID
(2 % NITROGLYCERINE) OINTMENT AS AN AID TO VENEPUNCTURE
Sir,—Venepuncture is the most common procedure undertaken by an anaesthetist. Indeed, it may be the only occasion on which he inflicts pain upon his patient. Thus, any method which might render venepuncture easier, simpler and less painful to the patient (without side effect) will be a welcome addition to the anaesthetist's armamentarium.

Application of tourniquet, tapping or stroking the veins, vigorous swabbing with spirit, clenching the fist, hanging the forearm downwards and application of local warmth are commonly used as aids to venepuncture. Since nitroglycerine ointment has been used to produce coronary vasodilatation, we studied the use of nitroglycerine ointment as a means of producing cutaneous vasodilatation before venepuncture.

A 1-cm length of the ointment was rubbed on the dorsum of the hand. Status of the veins was classed as invisible, visible, dilated and palpable before and after the application. Ease with which the venepuncture could be made 20 min after the application of the ointment was recorded.

The study included 30 patients. In 28, there was a change in the status of the veins after the application of the ointment. In all, venepuncture could be performed at the first attempt. There were no side effects. Only one patient complained of mild transient headache.

In our opinion, this technique appears to be useful, simple and time saving. It also reduces the pain, trauma and discomfort to the patient, especially those with veins which would otherwise be difficult to puncture.

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