REFERENCE

USE OF PROPOFOL IN A PATIENT WITH PORPHYRIA
Sir,—In response to a recent article in your journal by Mitterschiffthaler and colleagues [1], reporting the safe use of propofol in a patient with acute intermittent porphyria (AIP), I report a further uneventful use of the drug in this condition.

The patient, a 63-yr-old lady diagnosed several years previously as suffering from porphyria, presented for exploration and repair of a penetrating eye injury. Ten years previously she had been anaesthetized uneventfully for a cholecystectomy, but the notes for this operation were unavailable.

Anaesthesia was induced using fentanyl 0.1 mg and propofol 100 mg. Atracurium 35 mg was given, and the lungs were ventilated with a mixture of 66 % nitrous oxide and isoflurane in oxygen. Arterial pressure, heart rate and ECG were monitored throughout the procedure.

Anaesthesia and recovery proceeded uneventfully and after operation the patient suffered no adverse neurological or vascular sequelae. I believe this to be the third reported use of propofol in porphyria [1,2].

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SPINAL ANAESTHESIA AND SURGICAL BLOOD LOSS
Sir,—The literature relating to the influence of anaesthetic techniques on surgical blood loss is sparse and ambiguous. Some reports suggest that induced hypotension and spinal anaesthesia have no effect [1–6], while orthodox opinion remains indifferent to, or unaware of, new evidence.

In a recent prospective study of this subject during large bowel surgery, 47 patients were reported to have lost a mean of 105 (SD 250) ml after spinal anaesthesia, and after inhalation anaesthesia, 51 patients lost 288 (288) ml. The authors concluded that spinal anaesthesia and the associated hypotension, reduced blood loss significantly (P < 0.001) [7].

These results were disappointing because they made no contribution to the resolution of the blood loss controversy. Given the range and distribution of their data, the authors used an unspecified method of statistical analysis which appears to have been inappropriate, because these results are incapable of interpretation. Also, insufficient data were published to allow their conclusions to be verified.

These data might have been better presented as a scatter diagram of blood loss plotted against arterial pressure. This simple expedient should demonstrate at a glance any relationship which may exist between these two factors, and its degree. It would also avoid misleading those clinicians who may have only a limited understanding of numbers. Whatever method is used, those of us who have an interest in this field would be most grateful to have these matters clarified.

J. R. Donald
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Sir,—Thank you for the opportunity of replying to Dr Donald’s letter. We cannot agree with Dr Donald that the data regarding blood loss are incapable of interpretation. Figure 1 was included in the paper to demonstrate the distribution of blood loss in the two groups, and shows clearly that the large majority of patients who received spinal anaesthesia had an estimated blood loss of less than 100 ml, while the blood loss exceeded 300 ml in more than 30 % of those who underwent conventional general anaesthesia. The standard deviation was high in the spinal group because one patient had a blood loss in excess of 700 ml. The statistical test used was the Wilcoxon rank sum test, and is entirely appropriate for analysis of data which are not distributed normally. A second figure which showed the distribution of reduction in arterial pressure in the two groups was removed by the editor. However, we do not believe that clinicians who studied figure 1 in conjunction with the values in the text could regard the data as “misleading”.

The main purpose of the investigation was to identify any effect of spinal anaesthesia on the incidence of disruption of large bowel anastomoses, and not to resolve “the blood loss controversy”.

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The primary purpose of this study was to compare the rate of anastomotic dehiscence following spinal anaesthesia with that following general anaesthesia, and not to determine the mechanism of reduction in blood loss achieved by the former technique; this would have demanded measurements of vascular filling pressures and flow, in addition to mean arterial pressure. The figure which we deleted was a simple graph of distribution of intermittent measurements of systolic arterial pressure by sphygmomanometry; this would not have helped Dr Donald, was irrelevant to the discussion and was therefore deleted.

Although the type of statistical test was not specified in the results section of the paper in question, it was stated clearly in the methods section that three statistical tests were applied “as appropriate”, implying that parametric tests would not be used for non-parametric data, as confirmed in the authors’ letter.

Editor