Sir,—Thank you for the chance to comment on the letters concerning the editorial "Airways Revisited".

I did not state that transtracheal ventilation is unethical, all I said was that it may be considered so in normal patients. Injection of local anaesthesia does not need the great pressure that oxygen requires delivered through the cricothyroid membrane cannula. I do not use blind nasal intubation and I do not teach the technique as I believe it is no longer necessary. Trauma, bleeding peroperatively and postoperative problems are no longer acceptable to me.

Further, I would not agree with Dr Layman on the matter of informed consent. The technique of tracheal intubation is accomplished by inserting a light source (a laryngoscope). The fibreoptic laryngoscope is merely another method which must be used, albeit after it has been taught correctly.

The comments by Charters and colleagues are accepted for the most part. However, I still believe their investigations remain more academic than practical. If anaesthetists wish to confirm correct tracheal intubation by tactile method, they are free to do so. Certainly, I have not found a great desire to do so by colleagues at home or abroad. Equipment may be sterilized, but infected anaesthetists may not be quite so easy to treat.

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PARAVERTEBRAL BLOCK FOR POST-CHOLECYSTECTOMY PAIN RELIEF

Sir,—Giesecke and colleagues [1] suggested the use of paravertebral block for post-cholecystectomy pain relief, and to diminish the intraoperative response to noxious stimuli. It would be of interest to know the concentration of bupivacaine used, the concentration of adrenaline (if any), and the level at which the blocks were performed in that study.

I have conducted a pilot study in 20 patients undergoing cholecystectomy through a subcostal incision, where paravertebral block using the technique suggested by Eason and Wyatt [2] was used for postoperative pain relief. Twenty millilitre of 0.5% bupivacaine, plain or with adrenaline 1:200000 (in alternate patients) was used at the level of T7. In patients receiving bupivacaine plain the duration of analgesia was 1–3 h and in those in the adrenaline group duration was 3–8 h. There was no pain relief in three patients, which could be attributed to failed technique.

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REFERENCES


Sir,—In answer to the questions raised by Dr Kumar: the concentration of bupivacaine used for the paravertebral blocks in our study was 0.5%. There was no addition of adrenaline. Bupivacaine 20 ml was injected at T8. Excellent analgesia was attained for a minimum of 6 h in all patients studied.

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