CORRESPONDENCE

TRANSDERMAL HYOSCINE AND POSTOPERATIVE NAUSEA AND VOMITING

Sir,—I refer to the recent double-blind comparison by Koski and colleagues [1] involving different types of surgery, in which transdermal hyoscine was found to be of no benefit in reducing the incidence of nausea and vomiting after operation. A recent study by Bailey and colleagues [2] concluded that transdermal hyoscine was an effective antiemetic in patients undergoing outpatient laparoscopy. This appears to be in accordance with the account given by Palazzo and Strunin [3] which described a lower incidence of nausea and vomiting in gynaecological operations than in intra-abdominal operations.

The strength of opioid analgesia used may be significant. The doses of fentanyl used by Koski [4] (3–5 μg kg⁻¹) were greater than those used by Bailey and colleagues [2] (0.5–2 μg kg⁻¹), and a previous study in which less potent analgesia was used (morphine and pethidine) [5] found transdermal hyoscine was effective even in patients undergoing different types of surgery. These limited studies on the prophylactic use of transdermal hyoscine suggest that its effectiveness may be affected by the potency of analgesia used.

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REFERENCES

In a study just completed, we induced and maintained anaesthesia in a way similar to that described by Bailey and colleagues [2], but administered only 0.1 mg of fentanyl to inpatients undergoing laparoscopy. In recovery, only 5% of these patients vomited and no more made spontaneous complaints of nausea. Only when questioned specifically, 15% admitted feeling nauseated. In the postoperative ward, 15% of patients vomited within the first 8 h after operation. However, solid food was tolerated by 65% and liquids by 30% at the evening meal time. These initial results suggest that the tendency to nausea, vomiting, or both, may be reduced by maintaining anaesthesia mainly with inhalation anaesthetic agents and limiting the peroperative dose of analgesics.

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FAILED TRACHEAL INTUBATION

Sir,—I should like to add one or two comments to the excellent review by King and Adams [1]. White and Panjabi [2] believe that flexion/extension movements at the atlanto-occipital and atlanto-axial joints are more or less equal and that they function as a unit, “the occipito-atlanto-axial (OAA) complex”. King and Adams appear to suggest that bone structure limits movement at the OAA complex. I expect they refer to diseased patients (congenital or acquired), as flexion/extension movements of the OAA complex are not limited normally by abutment of the bones but by the tectorial membrane, which is the prolongation of the posterior longitudinal ligament inserted on the anterior rim of the foramen magnum. This accounts for those patients, with clinically poor top end movement, who have radiographically satisfactory separation of C0, C1 and C2.

We are performing a prospective study of difficult intubation in patients with diseased cervical spines. It is already quite clear that an absent atlanto-axial gap is a more powerful discriminant than an absent atlanto-occipital gap. Flexion/extension lateral radiographs are required to diagnose an absent gap [3]. A “neutral” view is acceptable if there are good gaps, but when they appear to be absent, one questions if it was a truly neutral position.

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