Our experience over 4 yr with direct questioning of patients reassures us that hypnosis and haemodynamic stability are provided reliably by the second method. We are currently investigating the dose, and evaluating the haemodynamic effects of propofol for induction and maintenance of hypnosis in the presence of full opioid analgesia in patients undergoing cardiac surgery.

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N. J. MASSEY
Sheffield

EXTRADURAL, SPINAL OR COMBINED BLOCK FOR OBSTETRIC SURGICAL ANAESTHESIA

Sir,—Dr Carrie, in an otherwise excellent review of regional anaesthesia in operative obstetrics [1], dismisses the practice of warming bupivacaine before extradural injection as being inconvenient and hardly merited because of a reduction of block onset time of only 20%. In this respect, he quotes our study [2] which recorded a reduction of 30% in onset time. Moreover, we demonstrated a 23% reduction in volume of local anaesthetic required to achieve satisfactory block, and a significant reduction in the incidence of shivering by injecting bupivacaine warmed previously to body temperature.

Maintaining a small supply of bupivacaine and 20 ml syringes in a thermostatically controlled warming cabinet (a standard fixture in any labour suite or operating theatre) does not impose any measure of inconvenience. There is no necessity to warm any other equipment and we continue to believe that this simple measure significantly improves the technique of extradural anaesthesia for Caesarean section.

D. A. DUTTON
J. E. HOWIE
Glasgow

REFERENCES


Sir,—I am grateful for the opportunity to thank Drs Dutton and Howie for their kind remarks about my review article [1] and to comment on the points they raise in their letter.

When discussing the effect of warming local anaesthetic solutions to increase the speed of onset of extradural block, I made reference not only to the work of Dutton and Howie [2], but also to that of Mehta and colleagues [3], whose reduction of onset time of block to T6 was only 21%. A “mean” of the two papers does give a reduction time of 25% so my figure of “about 20%” is only marginally low for the combined results, but underestimates by a few more per cent the 30% reported by Dutton and Howie. I apologize. Their observations on the effect of warming on reduction in volume of local anaesthetic and a reduced incidence of shivering were noted also by Mehta and colleagues, but my comments on the effect of warming were confined to the effect on rate of onset.

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What causes me anxiety is their comment about keeping bupivacaine ampoules in a “thermostatically controlled warming cabinet, a standard fixture in any labour suite or operating theatre.” Such cabinets do exist, but theatre staff disagree both as to the function of these cabinets and the temperature at which they should be kept. A survey of 11 such cabinets in this district showed a range of temperatures from room temperature (thermostat not functioning) to an alarming 67 °C, with several set at about 50 °C! The consequences of injecting local anaesthetic solution into the extradural space at these greater temperatures might be disastrous. Precise testing of the temperature of the sterile solution is almost impossible, and judgement of temperature through syringes, rubber gloves etc., inaccurate. While temperature is likely to be carefully controlled in the hands of clinicians such as Drs Dutton and Howie, I should feel some trepidation were a wave of enthusiasm for warm bupivacaine to sweep the U.K.!

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COMPARISON OF DOPAMINE AND DOPEXAMINE

Sir,—The report by Stephan and colleagues [1] comparing the effects of dopexamine and dopamine on cardiovascular and renal haemodynamics gives rise to several areas of concern.

First, the doses of dopexamine and dopamine chosen were not comparable. The authors state that dopexamine has only 33 % of the potency of dopamine at DA_1 receptors, yet they chose to compare dopexamine 1, 2 and 4 ug kg^-1 min^-1 with dopamine 2.5 and 5 ug kg^-1 min^-1. Likewise, the dose ranges allow no direct comparison of cardiovascular variables between the groups. Changes in cardiac index and systemic vascular resistance occur with dopexamine at a low dose, whilst dopamine in greater doses does not cause a similar increase in cardiac index and decrease in systemic vascular resistance. Again, this may be predicted from the known receptor pharmacology of these agents. The authors comment on the acceptability of the increase in heart rate seen with dopexamine 4 ug kg^-1 min^-1, which resulted also in a 117 % increase in cardiac index. We would conclude that, in this population of patients, this dose is unnecessary and excessive.

Second, the authors noted that the increase in renal blood flow was greater than that in cardiac index in those receiving dopamine, the reverse being the case with dopexamine. However, the increase in renal blood flow was not significantly greater with dopamine than with dopexamine, and the decrease in renal vascular resistance was greater with dopexamine.

All patients received calcium channel blockers and some were receiving β-blockers also. There is no comment on