The aetiology of vomiting after strabismus surgery is likely to be different from that following tonsillectomy, and is thought to involve traction on the extraocular muscles or postoperative ophthalmic imbalance [5]. In the study by Lewis and colleagues, morphine 0.1 mg kg⁻¹ was administered i.v. to all patients and the incidence of vomiting was 82% and 94% in the control and treatment groups, respectively [6]. This compares with control group incidences of 41-60% in most previous studies [5, 7-9], although an incidence of 85%, has been reported [10]. We have studied invasive P6 acupuncture administered after induction of anaesthesia in children undergoing strabismus surgery and found it to be the same as pretreatment with i.v. droperidol 0.075 mg kg⁻¹, although we suspect that this result demonstrates the inefficacy of droperidol in this situation rather than any efficacy of acupuncture, as the incidence of vomiting was high in both groups [11].

The incidence of vomiting after strabismus surgery may be underestimated if vomiting at home is not included, as patients usually stay in hospital for only a few hours. This is likely to be less of a problem with tonsillectomy, for which patients are routinely admitted overnight.

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ACUPRESSURE AND POSTOPERATIVE VOMITING IN STRABISMUS CORRECTION

Sir,—We read with interest the article by Lewis and colleagues [1] studying the preventive effect of the pressure of the P6 acupuncture point (Neikuan) on postoperative vomiting in children after strabismus correction. The authors justify the choice of this particular acupuncture point (sixth point on the pericardial meridian) as its antiemetic efficacy has been demonstrated in adults by Dundee’s team at the Belfast City Hospital [2, 3]. The negative result obtained [1] is not surprising if one refers to the physiopathological basis of Traditional Chinese Medicine (TCM).

In Western allopathic medicine, the efficacy of a chemical treatment upon one symptom often leads to the belief that this treatment should be effective whatever the aetiology of the symptom. In contrast, in TCM the treatment of the symptom depends on its aetiology. Thus the antiemetic effect of P6 in minor gynaecological surgery [2, 3] is logical because in this case postoperative vomiting may be primarily a result of the effect of the anaesthetic drugs. According to TCM, P6 would regulate the energy ("chi") of the "middle hearth” and would bring down the ‘Yin chi’. However P6 may act only on hollow organs ("fu"). In surgical strabismus correction, the frequency of vomiting is particularly great, probably because of the peroperative manipulation of the eye and its muscles. Thus, in this situation, P6 may not be very effective as it does not act on the eye which is a full organ ("yin") located in the "superior hearth”.

Knowledge of the TCM basis indicates that the following points might be more relevant: Bladder 10, (Tianzhu) which is a sedative point of the parasympathetic system; Bladder 11 (DaZhu), which strengthens the Yin energy of the eye; Gall-bladder 34 (Yanglingquang), which is the joining point of the energy of tendons and muscles. The dispersal of this point will diminish the parasympathetic stimulation resulting from surgical traction on the eye muscles.

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COMBINED SPINAL–EXTRADURAL ANAESTHESIA IN OBSTETRICS

Sir,—It is surprising how much information one may obtain on occasions from a small letter compared with a long article. I refer to the interesting letter of Dr Brownridge [1] concerning combined spinal–extradural anaesthesia in obstetrics. Dr Brownridge reported his surprise at having no postdural puncture headaches in about 1000 sections in 15 yr, and his explanation, the use of extradural pethidine in saline for up to 48 h after surgery is, I believe, correct. I wish to refer him to three letters in which I reported that I have treated postdural puncture headache with extradural morphine [2-4].

Incidentally, I should draw your readers’ attention to the fact that the first report of combined spinal–extradural anaesthesia was that by Curelaru [5].

Another point in Dr Brownridge’s letter in which, in my opinion, he is also correct, is that the “needle-through-needle” approach is dangerous. He is concerned about damage to the spinal needle tip during its passage through the extradural needle, just before entering the dura, and mentioned also the possible delay which may occur because of the difficulty in threading the extradural catheter after injection of the spinal solution. Again, I refer Dr Brownridge to my letters on the same problems [6, 7]. I should also refer him to the Eldor needle, or the combined spinal–extradural needle, which has been described previously [8-11], in which there are two lumens for each purpose and the extradural catheter is placed before the spinal anaesthetic.

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