USE OF DRUGS IN CHILDREN

Sir,—The problems of introducing new and potentially beneficial, but unlicensed, drugs into paediatric practice is underlined by the disclaimer published recently in your Journal [1]. Many drugs in regular use in adult practice are not licensed for use in children, and physicians face an ethical and possibly medico-legal dilemma if they wish to exploit the special benefits advertised for these agents in children in their care. This problem has existed for many years [2], and yet little has been done to improve the situation [3]. It seems that, after an agent has received its general licence, the hitherto overwhelming interest in developmental projects shown by the manufacturer dissipates rapidly, and requests for assistance with the drug, whether met by a polite refusal, usually on the grounds that newer compounds are taking precedence, or that paediatric research is ethically more difficult.

Surely, if a company believes its product is superior to its predecessors, then it should be duty bound to undertake adequate investigation to make this product available to all patients and physicians. Perhaps if licences were granted only to drugs which have been investigated across the age ranges, some of the apparent “ethical” difficulties could be overcome.

J. STEVENS


HYPOXIA AFTER DENTAL ANAESTHESIA

Sir,—We were interested in the study by Dr Lanigan on oxygen desaturation after dental anaesthesia [1] and agree that hypoxia is a frequent occurrence after short outpatient dental procedures. He found also that the use of supplementary oxygen during recovery did not affect the incidence of desaturation. Dr Lanigan suggests that failure to recognize airway obstruction may be an important factor in the aetiology of these desaturations. We would agree that airway maintenance is essential to the avoidance of hypoxia at this time and we present further data to confirm this.

A study of the use of the laryngeal mask for dental outpatient anaesthesia has been published previously [2]. Many drugs in regular use in adult practice are not licensed for use in children, and physicians face an ethical and possibly medico-legal dilemma if they wish to exploit the special benefits advertised for these agents in children in their care. This problem has existed for many years [2], and yet little has been done to improve the situation [3]. It seems that, after an agent has received its general licence, the hitherto overwhelming interest in developmental projects shown by the manufacturer dissipates rapidly, and requests for assistance with the drug, whether met by a polite refusal, usually on the grounds that newer compounds are taking precedence, or that paediatric research is ethically more difficult.

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J. STEVENS


MATERNAL AND FETAL HAEMODYNAMIC EFFECTS OF SPINAL AND EXTRADURAL ANAESTHESIA FOR ELECTIVE CAESAREAN SECTION

Sir,—We read with interest the article by Robson and colleagues [1]. Close analysis of the spinal group shows that, before any intervention, the average cardiac outputs were 6.73, 6.75 and 7.36 litre min⁻¹ at 5, 10 and 15 min, respectively. There was no significant difference between basal and postspinal cardiac output, and at 15 min cardiac output was on average 400 ml greater. This questions why mothers who have the same average cardiac output before and after spinal anaesthesia gave birth to babies whose average umbilical pH at birth was as low as 7.22. One possible reason for this is that aorto-caval compression was still present in this group of patients.

Evidence to support this hypothesis is present if a comparison is made of total peripheral resistance (TPR) between the extradural and spinal groups: basal TPR was 1087 and 1031 dyne cm⁻⁵ litre⁻¹ at 5, 10 and 15 min, respectively. However, after the institution of regional anaesthesia, the spinal group had consistently greater TPR. In fact, at 10 min (by which time one would expect full sympathetic block to be present in the spinal group but not in the extradural group) the TPR was 15% greater in the spinal group. In addition, although skin incision—delivery times were recorded, uterine incision—delivery (U-D) time is a more sensitive measurement. With such small groups, prolonged U-D times in as few as two patients might adversely affect the average umbilical artery pH. Furthermore, it is not evident from the methods whether or not any of these patients received oxygen after institution of regional...