CORRESPONDENCE

hyperbaric 0.5% bupivacaine. These studies demonstrated nicely that there are always patients who have a low block and others with an unnecessarily high spread of analgesia, irrespective of density of solution.

Our conclusion was not "that individual anatomical properties are more important than baricity". We have stated: "Individual anatomical properties may play a more important role than expected in the subarachnoid spread of local anaesthetic" and "The extent of block is affected also by the baricity of the solution in relation with the position of the patient". Our conclusions were based, first, on the results in all three groups of this study; second, on our earlier studies on repeated spinal anaesthesia [5,6]; and third, on the findings by Stienstra and van Poorten [7] and Mitchell and colleagues [8].

We are ready to accept new opinions on the prediction of spread of spinal anaesthesia, but what is needed most is greater knowledge of the anatomical-physiological determinants relative to the block in the individual patient.

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2. Tuominen M, Kalso E, Rosenberg PH. Effects of posture on the spread of spinal anaesthesia with isobaric 0.75% or 0.5% bupivacaine. British Journal of Anaesthesia 1982; 54: 313-318.
4. Taivainen T, Tuominen M, Rosenberg PH. Influence of obesity on the spread of spinal anaesthesia after injection of plain 0.5% bupivacaine at the L3-4 or L4-5 interspace. British Journal of Anaesthesia 1990; 64: 542-546.
8. Mitchell RWD, Bowler GMR, Scott DB, Edström HH. Effects of posture and baricity on spinal anaesthesia with 0.5% bupivacaine 5 ml. British Journal of Anaesthesia 1988; 61: 139-143.

PROPOFOL IN URAEMIC PATIENTS

Sir,—I am sorry to learn that O'Kelly, Lawes and Luntley [1] have not found the bleeding time to be a useful clinical tool. They suggest that the Editorial in the Lancet [2] states that the bleeding time is of little relevance in patients before regional anaesthesia. However, the Editorial states "used judiciously, the bleeding time deserves to remain as part of the assessment of individual patients with histories suggestive of bleeding disorders".

The problems of aspirin in obstetric patients are as follows: aspirin causes platelet dysfunction; platelet dysfunction prolongs the bleeding time; the incidence of venous puncture is about 18% during siting of an extradural catheter; if the bleeding time is prolonged will there be a significantly increased volume of blood in the extradural space?; what volume of blood is required to produce an extradural haematoma which will cause neurological deficit? Until we know the answers to the last two of these points, I am still of the opinion that a bleeding time should be performed on all patients receiving aspirin, before an extradural is sited. Armed with the result, anaesthetists are better able to deliberate the advantages and disadvantages of extradural block; for example if subarachnoid block might be more appropriate. They can also choose a technique designed to reduce the incidence of vessel puncture.

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Sir,—Drs O'Kelly, Lawes and Luntley recently attempted to assess the use of the skin bleeding time in clinical practice, and suggested that it was an unreliable test [1]. I would suggest that their paper contained serious errors of methodology which render any conclusions invalid.

In the methods section, the authors state that the estimation of bleeding time was "as described in the Simplate II test package", and that "a standard cut" was made using this spring loaded device. They do not mention that the Simplate II template device has two blades and makes two cuts (hence the "II"), and that the mean of the two measured bleeding times is recorded. There is, indeed, another apparatus, "Simplate", from the same manufacturers (General Diagnostics, Orkanen Teknika), which only makes one cut. Are the authors able to tell us exactly which template device they used for their study?