EDITORIAL II—THE NATIONAL CONFIDENTIAL ENQUIRY INTO PERIOPERATIVE DEATHS

Sirs,—There are so many errors of fact in your editorial that we consider that it is essential that you be corrected. Your Journal may have limited appeal outside the specialty, but it would be disappointing if the work of the National Enquiry into Perioperative Deaths were to be misunderstood by anaesthetists as a result of this misleading item.

It is true that many departments of anaesthesia do have morbidity and mortality meetings: but by no means all deaths in our study (37%) were considered by such meetings (Table 82 in the Report). Surgeons are better than they used to be and now have more meetings, but not yet have they reached the standard set by anaesthetists. Sadly, combined meetings are still uncommon (36%).

It is difficult to understand how a study of death [1] could as you allege have been prospective; obviously it was not. Beecher and Todd, as anesthesiologists, studied 10 University hospitals [2] and a sole surgeon was an adviser. There was little if any consideration of surgical factors in that study, and the British efforts are unique in this respect. We did not repeat what was already done before. NCEPOD studied three different regions in the U.K.—South Western, Northern and North East Thames, the last being the only Metropolitan one. Northern Ireland (not to mention the Channel Islands and the Isle of Man) are included in NCEPOD.

One important epidemiological point that you overlooked was that the sample of deaths in our most recent enquiry was random. We welcome your muted disappointment that the results of questionnaires were incomplete, since the reliability of such a sample can therefore be legitimately questioned. Now we merely want to encourage all your readers to return their questionnaires as promptly as possible, and we have changed the method of distribution in the hope that this will be achieved.

Surgeons have better arrangements for clinical consultation within their teams than do anaesthetists and there is little justification for complacency; anaesthetists need to do better and we would have expected the official journal of the Royal College of Anaesthetists to state this unequivocally.

Our report does, indeed, contain many anecdotes (68 to do with anaesthesia), but these are supportive and illustrative of data contained in 88 tables of hard information. These data are available nowhere else. Finally, it might help those who still want to acquire accurate information about this enquiry if you were to publish not only this letter, but also the fact that the series of articles on the examination of the technique I choose, but does reflect the patient's expectations of my knowledge and experience. Clinicians must recognize the responsibility that this places upon them and act accordingly.

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Aberdeen Royal Infirmary
Aberdeen

2. Beecher HK, Todd DP. A study of the deaths associated with

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BACTERIAL RETENTION PROPERTIES OF HEAT AND MOISTURE EXCHANGE FILTERS

Sirs,—We wish to comment on the paper by M. G. Lee and colleagues, published in British Journal of Anaesthesia [1].

The statement that “The aim of this study was to compare the bacterial filtration properties of HMEF currently available” is incorrect, as the Darex HMEF is “Not currently available”. The trials carried out on the five units they had in their possession were on old American stock supplied circa 1985; also, the trade name Darex was withdrawn more than 4 years ago. Information was conveyed to the authors of the current position of Dar products in early 1991.

D. Fox
Mediplan-Dar Ltd
Warwick


Sirs,—When the study of the filtration properties of HME filters began in late 1989, we attempted to obtain samples of all products that were then available commercially. At that time, the Darex filter was made available to us by a marketing intermediary, a situation not uncommon with many medical and surgical items.

I accept Mr Fox's contention that the units were old stock that is no longer available and it is true we were informed of this fact. As a consequence, a reference to this was included subsequently in the discussion, paragraph 6 of the section headed RESULTS.

M. G. Lee
Mersey R.H.A.
Liverpool

PROPOFOL AND ALFENTANIL MIXTURE

Sirs,—I read with interest the paper by Taylor and colleagues [1]. The authors have shown that propofol and alfentanil may be administered as a mixture with no signs of altered pharmacodynamics. Despite the fact that Kay reported in 1986 [2] that infusion of a mixture of propofol and alfentanil had been undertaken in 21 patients with no signs of adverse outcome, mixing of these drugs has to be avoided for several years. This is probably because of the limited knowledge of the physiochemical, bacteriological, pharmacokinetic and pharmacodynamic properties of such mixtures. However, in addition to the paper by Taylor and colleagues, three papers of relevance to the possibility of using propofol and alfentanil mixture have been published this year [3–5], and three of the four previously mentioned theorectical shortcomings have been examined, with encouraging results. However, the pharmacodynamic properties remain to be investigated in patients undergoing mechanically controlled ventilation (i.e. if the use of a fixed dose of propofol and alfentanil causes overdosing in any respect).

During the past 3 yr, 2069 patients (aged 2–88 yr) have been anesthetized in our department with a mixture of propofol and alfentanil for procedures requiring tracheal intubation and mechanically controlled ventilation (15% abdominal surgery with a concomitant extradural block), and we have found few indications of an unfavourable pharmacodynamic action. This letter is aimed to inform others about our preliminary experience concerning the practical use of this mixture. Naloxone has been used to antagonize the opioid effect in six of these patients, and the elapsed time from end of the infusion to tracheal extubation was a mean of 11.2 min in 612 consecutive patients without extradural block (average duration of surgery 54 (20–60) min). The latter result is very similar to that found by Schütter and colleagues [6], using separate computer-assisted infusions. As our data are retrospective, a controlled, prospective study is being performed currently. Furthermore, four cases of conscious awareness have been identified in the 2069 patients. Thus the prevalence of awareness is similar to that found by Liu and colleagues [7]. Two of our cases of conscious awareness were of a technical nature and