First, it is no longer possible to use the white band of the front cover for recording of progress, completed reading or pages/references for storing.

Second, we feel sure that we are not the only anaesthetists who have neither the space nor the time for journals at work and who receive journals at home. One colleague admits to storing journals in the garage. (Is the new cover designed to be more waterproof?)

Work space at home is limited and the floor may become a useful cover for recording of progress, completed reading or pages/references. Where this journal is concerned, anaesthetists should tread lightly.

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CONTINUOUS SUBDURAL BLOCK

Sir,—The report of continuous subdural block by Collier, Gatt and Lockley [1] raises some issues about the management of a suspected subdural block. In many instances, the diagnosis is made with certainty only in retrospect, by radiological contrast studies, and there are few guidelines to help at the time of uncertainty when the differential diagnosis between intrathecal block or multicomartment block may not be clear. In such circumstances, many would apply the “if in doubt, take it out” maxim and possibly attempt either to repeat the extradural at another space or perform a subarachnoid block. If credence is given to the postulate that large volumes of subdural local anaesthetic may cause neurological damage by compressing spinal nerve roots, blood vessels or the cord [2], repeating the extradural at an adjacent space may exacerbate such a compressive effect. As the subarachnoid contents may be displaced by subdural fluid [2], locating the subarachnoid block may be more difficult, or the height of block affected. Given appropriate monitoring, small volume continuous subdural analgesia may be applied safely, but perhaps with greater safety using single end-hole rather than multihole extradural catheters.

Unlike Dr Collier’s patient, I found that prolonged postoperative analgesia was a feature with subdural fentanyl 50 μg in operative analgesia was a feature with subdural fentanyl 50 μg in requirement any postoperative analgesia.

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Sir,—I read with interest Dr Runcie’s letter [1] concerning the article by Berridge which described the influence of cardiac output on the correlation between mixed venous and central venous oxygen saturation [2]. Dr Runcie correctly pointed out that the statistical analysis of the data should examine the difference between mixed venous and central venous oxygen saturation and not the correlation between them. However, as has been noted previously [3], the original Bland-Altman technique [4] is not invariably an appropriate method for comparing two measurements: it is intended to determine the agreement between two methods of clinical measurement of a variable, when neither of the methods is sufficiently accurate to be considered a “gold standard”. In this method, the difference between the measurements is plotted against the mean of the two measurements, the mean of the measurements (rather than one or other of the two) being used as the independent variable for two reasons:

1. When both measurements are subject to an unknown error, the best estimate of the true value of the variable is the mean of the two measurements [4]. This is not likely to be the case with Berridge’s data: the measured mixed venous oxygen saturation is almost certainly a better measure of the true mixed venous oxygen saturation than is the mean of the central venous and mixed venous saturations.

2. It is a well known statistical phenomenon that, if the difference between two values is plotted against one or the other, the difference is related to each of them [4]. For example, the expected correlation coefficient between the difference between

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