Anaesthesia datasets

Sir,—While I agree with the need for a minimum dataset for anaesthetic logbooks, particularly in light of the forthcoming changes in training, I am a little perturbed by the inclusion of names and dates of birth of patients.

Drs Lack, Stuart-Taylor and Tecklenburg [1] describe a minimum dataset for anaesthetic logbooks. In the data fields described, the name and the date of birth of patients are included. No distinction was made as to whether the ("electronic") logbooks were to be held on "home" computers or on "hospital" machines. According to the Data Protection Act of 1984 [2], records of the type described about living, identifiable individuals, place obli-
gations on those who record and use personal data. The users must be open about this use through the Data Protection Register. The Act does not cover information that is held and processed manually (ordinary paper files), and there are other exemptions, but many data users may find that as they cannot rely safely on the exemptions, they will need to register under the Act.

While departmental logbooks would be covered by registration of the hospital, individual logbooks on personal computers would not.

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Sir,—I am sorry that our article was not clear enough; the dataset referred to is for anaesthetic records of any type, not just logbooks.

I entirely agree on the subject of inclusion of personal identifiers in records; it is a very difficult topic. Clearly, any record of anaesthesia has to contain personal identifiers, and it is difficult to see precisely when, in the process of aggregation to produce reports and statistics, one should remove them. On the one hand there is a very understandable wish for a clinician to be able to review all the records of any particular recorded complication, but on the other hand, clinicians might take a very different view about recording complications if the reviewer were a lawyer.

The Royal College has set up a working party under the chairmanship of Professor Adams to discuss the content of both the anaesthetic record and the logbook, and it will report in due course. The minimum dataset (which we wrote about for records) and the recommended content of both (which has yet to be decided) are different.

Logbooks are a required part of training, but their value has been discussed unendingly. College visitors reviewing paper logbooks frequently find them almost worthless, containing much data but little information. Statistics from paper records are frequently found them almost worthless, containing much data but little information. Statistics from paper records are

Sir,—Dr ÓhAíseadha has the benefit of hindsight when he comments on our study. At the time of planning our study, no data on the incidence of gastric content aspiration in association with the use of a laryngeal mask during general anaesthesia were available. We were unable to find any prospective, randomized study published in an international journal specifically examining this issue. All previous studies investigating the incidence of gastric content aspiration had been carried out before the laryngeal mask was in common clinical practice. Our study was therefore the first to ascertain the incidence of gastric content aspiration when the laryngeal mask was used during general anaesthesia. Based on our results the sample size required to conclusively show a difference of 4% would be approximately 350.

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Acid aspiration syndrome in obstetrics

Sir,—The editorial on the latest Confidential Enquiry into Maternal Deaths raised the question of whether or not prophy-
lactic antacid therapy during labour should be restricted to only those women deemed to be "at risk" [1]. Although it is not possible to prove a causal relationship, there has been a decrease in the incidence of fatal obstetric acid aspiration syndrome during the past 10 yr in parallel with the increased prophylactic use of H2 receptor blocking drugs in labour [2]. Undoubtedly, improved training and increased use of regional anaesthetic techniques have contributed significantly, but we believe that the value of routine use of ranitidine in labour should not be underestimated.

Sodium citrate alone, as a single preanaesthetic dose, or multiple doses during labour, failed to reliably increase intragastric pH above 3 [3]. However, pH values greater than 3 were achieved with regular 6-hourly oral ranitidine, commenced at the onset of established labour and then combined with a preanaesthetic dose of sodium citrate [3].

Several obstetric units have adopted the policy of targeting ranitidine prophylaxis at high-risk patients (rather than pre-