Preoperative fasting for paediatric anaesthesia

Sir,—I refer to the recent review by Phillips, Daborn and Hatch [1]. Between 1991 and 1993 the Department of Anaesthetics in Newcastle examined the problem of preoperative fasting intervals for children presenting for routine surgery. An initial audit revealed that many children were undergoing prolonged fasts before anaesthesia. After reviewing the literature [2], a clear fluid fast of 2 h was chosen and guidelines circulated to anaesthetists and paediatric wards. About 6 months after these guidelines were introduced we repeated the audit. We investigated children undergoing ENT, general surgical and urological operations. The results are summarized in figure 1.

Before guidelines were introduced, children for morning lists had a median fasting interval of 13.1 h \((n = 266)\). After guidelines were introduced this decreased to 4.1 h \((n = 137)\). For children undergoing afternoon operations the median fasting interval before introduction of the guidelines was 6.4 h \((n = 152)\). After the guidelines were introduced this was reduced to 4.7 h \((n = 128)\). The ranges remained very wide, indicating that some children were still fasting for long periods. The proportion of children (morning and afternoon groups pooled) fasted for more than 12 h decreased from 54% in 1991 to 21% in 1993. The proportion of children taking a drink in the 8 h before surgery increased from 45% to 78% after guidelines were introduced. Overall these results are encouraging. They demonstrate clearly that in several cases the system failed badly. Reasons for this might include lack of awareness of the guidelines, poor communication with parents and nurses, and children deciding not to accept a drink when offered. Despite these problems I hope these results will encourage departments of anaesthesia to implement fasting guidelines, and serve as a warning that their effectiveness must be monitored.

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Haemodynamic effects of subarachnoid block in the elderly

Sir,—Dr Critchley and colleagues observed differences in the haemodynamic effects of subarachnoid block in elderly patients when they compared patients undergoing elective urological procedures with non-elective orthopaedic cases [1]. They suggested that hypertension was responsible for the haemodynamic differences between the two groups. However, they have overlooked two factors. First, central venous pressure does not have a simple relationship to blood volume and therefore blood loss in the orthopaedic group may still be a contributory factor. Second, there was no mention of duration of starvation, which is likely to be longer in the non-elective group and thus exaggerate the haemodynamic effects of subarachnoid block.

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Posterior column sensory impairment during ambulatory extradural analgesia in labour

Sir,—We read with interest the study by Buggy, Hughes and Gardiner [1] on posterior column impairment during ambulatory extradural analgesia in labour. While comprehensive evaluation of the ability to walk after low-dose extradural analgesia is to be welcomed, we question the authors’ conclusion that ambulation is not safe after the use of 15 ml of the extradural mixture (0.1% bupivacaine with fentanyl 2 μg ml\(^{-1}\)) because of significant posterior column impairment. There are several points to consider.

First, walking is still possible in patients with diminished posterior column sensation. For example, a diabetic patient with a peripheral neuropathy can still walk, despite distal proprioceptive loss. The physiology of walking is controlled by central pattern generators within the central nervous system which in turn depend on feedback information from three sources. These are the limb proprioceptors, the vestibular apparatus in the middle ear and the visual signals from the retina [2]. Only two of these three need to be intact for walking to proceed unimpaired.