exact time after intubation when mean arterial pressure was measured, and its value 5 or 10 min after intubation, when catecholamine release may have caused it to increase.

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Editor,—We are grateful for the opportunity to respond. The first point made was that we cannot conclude that this induction technique was clinically safe. We would disagree with this and use the evidence that none of our subjects was adversely affected clinically by the temporary decrease in arterial pressure. The second point was the exact timing after intubation of our measurement of arterial pressure. This was performed 60 s after intubation and was recorded at this time in an effort to show the maximum demonstrable decrease in arterial pressure. As one would expect from the pharmacokinetics of remifentanil, 5 or 10 min after intubation, arterial pressure had returned to baseline.

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Mental nerve neuropraxia associated with tracheal intubation using an RAE tube

Editor,—Nerve injury is a well documented occurrence in anaesthesia. In a review of more than 1500 anaesthesia-related malpractice claims, 15% were for nerve injury, of which ulnar nerve (34%), brachial plexus (23%) and lumbosacral nerve root (16%) injuries constituted the majority.1 Cranial nerve damage caused by orotracheal airway management is uncommon (<1% for individual nerves),1 although cases of bilateral vocal cord paralysis, recurrent laryngeal nerve palsy, lingual nerve and hypoglossal nerve injury have been attributed to tracheal intubation and the use of the laryngeal mask.2,3 We report a case of mental nerve neuropraxia associated with the use of an RAE tracheal tube.

A healthy 28-yr-old Saudi male (weight 98 kg, height 179 cm) with bilateral keratoconus was undergoing left eye epikeratoplasty under general anaesthesia. Premedication comprised hydroxyzine 100 mg and cimetidine 200 mg orally. Anaesthesia was induced with a bolus dose of fentanyl 1.5 μg kg⁻¹ and propofol 200 mg, and his trachea was intubated with a size 8.0 cuffed oral tracheal tube (Mallinckrodt RAE, Ireland) after neuromuscular block with atracurium 0.5 mg kg⁻¹. As is common practice in our institution, a tightly folded surgical gauze swab (approximately 3×3 cm) was placed as padding between the RAE tube and the patient’s chin to avoid pressure-related damage to the skin. Anaesthesia was maintained with 1% isoflurane and 65% nitrous oxide in oxygen. At the end of the procedure, lasting 1 h 55 min, his trachea was extubated uneventfully.

On the second day after operation, the patient complained of numbness of the lower lip and chin. Examination revealed sensory loss restricted predominantly to the distribution of the left mental nerve without intra- or extra-oral signs of trauma. No subjective improvement occurred over the next 2 days, much to the patient’s distress. On day 5 after operation, the patient admitted to partial return of sensation and was discharged with reassurance that there should be complete recovery.

To our knowledge, mental nerve neuropraxia after tracheal intubation using an RAE tube has not been described previously. In our case, it seems likely that pressure on the tracheal tube was transmitted via the surgical gauze padding, either because of external pressure from the surgical assistant or from excessively firm taping of the tube to the patient’s chin, resulting in injury to the nerve as it emerged from the mental foramen.

![Fig 1 Position of the RAE tracheal tube after taping and insertion of an oral airway. Gauze padding overlies the mental foramen.](image_url)
mental foramen. Although not clear from the anaesthetic notes, it is possible that the tube was secured to the left of the mid-line, hence the pattern of sensory loss (Fig. 1). It is now our practice to ensure that the RAE tracheal tube is secured exclusively in the mid-line.

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Hazards of laparoscopic surgery

Editor,—I feel it is appropriate, given the increase in laparoscopic surgery, to note one of the often overlooked hazards of this technique. During a recent laparoscopic cholecystectomy, I noticed an intense smell of burning, only to see a small plume of smoke rising from the tip of the laparoscope light source (Dyonics Halogen, Smith and Nephew Medical Ltd, Hull, UK) which had temporarily been laid on the drapes. The heat at the distal end of this halogen light is clearly sufficient to ignite flammable materials in close proximity to it. This particular light source was autoclavable and had not been in contact with flammable sterilizing solutions. The resulting damage is shown in Figure 1.

Fortunately, there was no harm to patient or staff, but the potential for thermal injury during laparoscopy should not be forgotten. The role of the anaesthetist in the prevention of fires and explosions in theatre is clearly as relevant today as it was 30 yr ago.

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Ropivacaine and bupivacaine for analgesia in labour

Editor,—We read with interest the recent meta-analysis of trials comparing ropivacaine and bupivacaine for analgesia in labour by Writer and colleagues.1 We must express concern with some of the methods the authors used, and in particular must question the claim of superior neonatal outcome.

All six studies in the meta-analysis compared 0.25% concentrations of the two local anaesthetics given either by bolus or continuous infusion. Whereas all of these studies found analgesia to be equivalent between the groups, and in vitro data notwithstanding, there is recent evidence that epidural ropivacaine is substantially less potent than epidural bupivacaine.2 Therefore, the comparison between the drugs may not have compared functionally equivalent doses.

Analysis of infants using the neonatal neurologic and adaptive capacity score (NACS) <35 is particularly disconcerting. First, the creators of this measure themselves argue that the number 35 was ‘arbitrarily chosen’ and would require ‘further experience with large numbers of infants’ to validate it.3 To our knowledge, we still await such validation. An editorial accompanying the publication of the NACS criticized specifically the summed score and the number 35 as being statistically inappropriate measures of neonatal neuropsychiatric status.

Second, Writer and colleagues used a stratified Mantel–Haenszel chi-square test to compare NACS <35 between the ropivacaine and bupivacaine groups. The stratification means that various strata of study, site and parity were analysed separately, then combined to yield the final P value. However, had all the data from the meta-analysis been from a single, large, randomized trial, the difference in NACS would not have been apparent (chi-square = 3.598, df=1, continuity-corrected P=0.1025). This would seem to imply that some subgroup of patients (i.e. stratum) demonstrated a much larger difference between groups than others. Which one(s) was it, and how do the authors explain the difference?

Third, the authors performed multiple pairwise comparisons between NACS scores and subscores and claimed a significance of P<0.05 for each. As the active tone and capacity scores are subsets of the total NACS, these cannot be viewed as independent measurements and some correction for multiple comparisons is required. Furthermore, the 2-h and 24-h tests should be treated as part of a repeated-measures analysis, as they are likely to be correlated.

Finally, the authors’ explanation for the difference in NACS at 24 h but not at 2 h is difficult to reconcile with

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3 Nagai K, Sakuramoto C, Goto F. Unilateral hypoglossal nerve paralysis following the use of a laryngeal mask airway. Anaesthesia 1994; 49: 603–4

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Fig 1 Damage to the drapes caused by the laparoscope light source.