been many recent reviews on the dangers posed by such weapons, detailing postulated treatment regimens.\(^3-6\)

It is evident that the treatment of such incidents will start, and may be confined initially to the pre-hospital arena. Much of the initial decontamination in such incidents will be the responsibility of the fire and ambulance service. The authors of both articles correctly point out these general points.\(^1,2\) It is also worth noting that organizations, such as the SAMU in France, have senior doctors with critical care skills as part of the integrated pre-hospital response to terrorist and mass casualty incidents. This is not currently the case in the UK. Doctors at the Helicopter Emergency Medical Service in London, undertake chemical incident training and form part of the major incident plan for specific large crowd events, when such attacks are threatened. However, it is unclear as to whether this is widespread within the NHS. Most hospital staff do not have the skills required to operate in the pre-hospital environment without further training and experience. All recent authors writing on this subject stress the need for large mass-casualty training exercises to make health workers truly prepared for such incidents, but there is little current evidence that this is being done. If the risk is as high as we are being lead to believe, then surely more resources need to be set aside to deal with this eventuality.

P. Shirley
London, UK

Editor—Thank you for asking me to respond to the points about chemical and biological casualties raised by Dr Shirley.

I think it very important that doctors and paramedical staff should be involved in the pre-hospital response to toxic incidents, either from terrorist activity or from accidental release. It is essential, however, that they receive proper training in the management of the incident in order to avoid becoming the next casualties. They should also plan and work closely with the fire service, who have special responsibility in the management of hazardous materials release.

Dr Shirley is correct in his observation about the integrated response of the medical services in France and other European countries where anaesthetists and emergency physicians are routinely involved in pre-hospital care. Apart from the Hospital Emergency Medical Service in London, I believe that this is not usually the case in the UK, with the important exception of incidents where patients may be trapped. Thus, first-hand medical care is provided on-site for the victims of train crashes and other disasters from doctors who have received special training in site safety, and who work closely with the other emergency services.

I believe that there is an important precedent from this situation for the management of casualties from toxic release. Here, also, patients may stay at the incident for some time owing to the need for decontamination and it is important that the same level of medical care be given to these patients as to those from physical entrapment.

To provide such care effectively and safely requires planning, equipment and training. Information about current UK initiatives relating to chemical and biological releases is available on the Department of Health emergency planning website.\(^7\)

Above all, the medical profession must give a clear message that casualties from terrorist chemical and biological release can be managed effectively. This will put the current public belief that such incidents automatically cause ‘mass destruction’ into a proper perspective.

D. J. Baker
Paris, France

Treatment of biological and chemical casualties in the UK

Editor—I would like to make comment on the comprehensive review by White,\(^1\) and the associated editorial by Baker,\(^2\) on the treatment of chemical and biological casualties. Recent world events have put these considerations into sharp focus. There have
The study compared post-Caesarean section analgesia to supplement spinal anaesthesia for Caesarean section? Intrathecal diamorphine or intrathecal fentanyl, especially for emergency Caesarean section. I believe that this would shift the overall risk/benefit ratio in favour of supplementing spinal anaesthesia with intrathecal fentanyl, rather than with an opioid could be given at Caesarean section. We thank Dr Cooper for his comments on our paper, but increasing spinal anaesthesia with intrathecal fentanyl, rather than with wrapped syringes containing pre-mixed solutions of fentanyl and bupivacaine were to become commercially available, this would increase the convenience, speed and safety, with which intrathecal reconstitution and dilution are not required. Another advantage of selecting between intrathecal diamorphine and intrathecal fentanyl. Intrathecal diamorphine was associated with lower i.v. morphine patient-controlled analgesia (PCA) use, and with a lower incidence of mild drowsiness at one of the assessment times, but postoperative pain and nausea scores were not significantly different. When i.v. morphine PCA was used, we found ourselves unable to agree with many of them. The use of anaesthesia and intensive care. Br J Anaesth 2002; 89: 306–24

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