Correspondence

5 Smith JE, Reid AP. Identifying the more patent nostril before nasotracheal intubation. Anaesthesia 2001; 56: 258–62
8 Singh S, Smith JE. Cardiovascular changes after the three stages of nasotracheal intubation. Br J Anaesth 2003; 91: 667–71
do:10.1093/bja/aei583

Minimum effective local anaesthetic dose for spinal anaesthesia

Editor—In their response1 to my criticisms2 of their paper3 Sell and colleagues accept some of my points, and refute others. On most of the latter we will simply have to agree to differ, but, not surprisingly, I cannot accept their quoting my own review4 in support of their belief that the solutions which they used were isobaric! Their quote from the article (‘Given the normal variation [of CSF], it is necessary that solutions that are to be predictably hypobaric or hyperbaric in all patients have baricities below 0.9990 or above 1.0010 respectively’) is correct, but it is taken out of context, and ignores the key relevance of the words ‘given the variability…’ and ‘predictably’, to say nothing of the arguments that follow in the rest of that paragraph.

These lead to the specific conclusion that the word ‘plain’ is a more appropriate descriptor so I would ask them to consider the paragraph in full, not just a selective quote.

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2 Wildsmith JAW. Correspondence: minimum effective local anaesthetic dose for spinal anaesthesia. Br J Anaesth 2005; 94: 865

do:10.1093/bja/aei584