

defining ethics, they believe that we have been acting unethically: they describe a typical case in which elective ventilation might be considered—a patient with a clearly diagnosed fatal cerebral injury who undergoes respiratory arrest. They write, “Deliberately prolonging a patient’s dying is unacceptable for any reason.” But such patients die when breathing ceases; elective ventilation does not prolong the act of dying, for one is ventilating a corpse. If that is wrong, let them tell us why, rather than differentiate between dead bodies on the basis of whether a diagnosis was made before or after death, or whether the patient stops breathing in the accident and emergency department rather than a medical ward.

We were taxed by ethical issues when we set up the elective ventilation protocol: ethics may be defined as what is right, and in turn that can be regarded as behaviour that causes no distress, offence, or indignity in the context of current societal values. To act ethically, firstly, we must respect the wishes of the dead and dying; secondly, we must cause no unnecessary distress to relatives; and, lastly, we must cause no emotional crisis for the staff of intensive care units. We know from many surveys of public opinion that over 70% of the public would wish their organs to be used for transplantation after death. In our unit one of the goals of elective ventilation is the respecting of these wishes.

It seemed to us illogical that patients who stop breathing before irreversible brain injury is diagnosed can become organ donors, whereas clinically identical patients who become apnoeic after diagnosis cannot. Such patients often differ only in the time taken to reach hospital, and to claim that they differ in any more fundamental way is pure sophistry. It is hard to see how the denial of a patient’s right to be an organ donor after death is ethical behaviour. The relatives of our electively ventilated organ donors do not feel that we act improperly; rather, they all consider that the process of organ donation allows them to make some sense of an otherwise inexplicable loss.<sup>3</sup>

It is sad that Park and colleagues have not understood the logical and moral basis of elective ventilation. We welcome this opportunity to restate our position and encourage other units to follow our lead.

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## Death rate from asthma

EDITOR,—Our experience supports W T Berrill’s conclusion that the death rate from asthma may be exaggerated.<sup>1</sup> In East and North Hertfordshire (estimated population 480 000) during 1986-91 inclusive, 114 deaths from asthma at all ages were reported by the Office of Population Censuses and Surveys. Even if the contribution of bronchial asthma to cause of death is interpreted generously—for example, part I of the death certificate states death from asthma and part II states chronic obstructive airways disease—only 63 of 100 deaths have so far been found to be attributable to asthma. Fourteen sets of records remain to be examined. The number of deaths in people aged over 65—22 of the 63—reduces the potential for saving lost

years of life. Only 19 of the 63 deaths occurred below the age of 45.

Taking into consideration the circumstances in which many of these deaths occurred, we believe that there will be only a small health gain from reducing mortality. We are therefore shifting some of our attention to exploring the opportunities for reducing morbidity. Meanwhile it would be of great help if the accuracy of death certification could be improved, possibly through audit. Initiatives to improve understanding of the burden of ill health due to asthma would be welcome.

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- 1 Berrill WT. Is the death rate from asthma exaggerated? Evidence from West Cumbria. *BMJ* 1993;306:193-4. (16 January.)

EDITOR,—W T Berrill implies that death should not be attributed to asthma in older people (over the age of 60) because asthma is “a disease of young people.”<sup>1</sup> Not only is reversible airways disease common in older adults<sup>2</sup> but, as with most other conditions, older people are probably more likely to die of it than younger people. Thus most people dying of asthma should be expected to be old.

Because of the underappreciation of asthma in elderly people such patients are treated with antibiotics for their respiratory infections but are left to suffer the dyspnoea and hazards of their respiratory obstruction.

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## Epidural analgesia in labour

EDITOR,—An item by Minerva may mislead readers.<sup>1</sup> It states that epidural analgesia with bupivacaine is associated with factors that adversely affect the infant, such as lower maternal self esteem, prolonged labour, use of oxytocin, and forceps delivery. No randomised study has ever shown that these negative aspects of childbirth are a result of epidural analgesia.

The study to which Minerva refers, by Sepkoski *et al*, compared women who received epidural analgesia, without randomisation, with poorly matched controls who had no pain relief; matching was based on criteria expected to affect the placental transfer of the local anaesthetic bupivacaine.<sup>2</sup> An attempt to match for the duration of the first and second stages of labour, the use of oxytocin, and the mode of delivery failed. The authors assume that these are a direct result of epidural analgesia and refer to work in which, again, randomisation was not done. It is not surprising that the women who had epidural analgesia had significantly longer labours, a greater requirement for oxytocin, and a higher rate of instrumental delivery as such factors increase the need for epidural analgesia and therefore cannot be assumed to result from it. Moreover, they may themselves affect neonatal behaviour and interaction between the mother and her infant. Non-randomised comparisons of epidural analgesia with no analgesia or other forms of pain relief are likely to be biased since those women experiencing long, difficult labours are more likely to request epidural analgesia.

Sepkoski *et al* used 0.5% bupivacaine in their study. This high concentration is unnecessary and

not standard practice in Britain as it results in an appreciable motor block, which impairs maternal satisfaction.<sup>3</sup>

There are studies in which neonatal assessment has been made after attempts at randomisation of analgesia during labour. In one, no adverse effects on neonatal outcome were found.<sup>4</sup> Other studies that were not randomised failed to show adverse effects on the baby. Indeed, in many studies epidural analgesia has been shown to be beneficial. Kangas-Saarela *et al* found that babies whose mothers had received epidural analgesia with bupivacaine had higher neurobehavioural scores than those whose mothers had not received such analgesia.<sup>5</sup> Two other studies showed no adverse effects of epidural bupivacaine in labour on neonatal neurobehavioural scores.<sup>6,7</sup>

Minerva should take the scientific methods used in papers into consideration. This would prevent questionable findings influencing a much wider readership.

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## Thromboembolic complications of laparoscopic cholecystectomy

EDITOR,—The incidence of deep venous thrombosis and pulmonary embolism in diagnostic laparoscopy is low. It was reported as 0.2 cases/1000 procedures in a confidential inquiry into 50 427 gynaecological laparoscopies.<sup>1</sup> In a single report of 100 laparoscopic salpingectomies deep venous thrombosis occurred in one patient.<sup>2</sup> Concern has been raised, however, about the increased potential for thromboembolism in patients undergoing laparoscopic cholecystectomy.<sup>3</sup> The true incidence of thromboembolism in this procedure is not known.

We have performed laparoscopic cholecystectomy on 438 patients, and thromboembolism has occurred in three: one deep venous thrombosis, one non-fatal pulmonary embolism, and one fatal pulmonary embolism. All three cases were confirmed by phlebography or ventilation-perfusion scanning or after death. Interestingly, two of the cases were diagnosed within four days of surgery, and both patients had been mobile up to the day of surgery. All three patients received prophylaxis with subcutaneous heparin and compression stockings. The patient with the deep venous thrombosis also had intraoperative stimulation of the calf. We believe that thrombosis of leg veins or pelvic veins occurred intraoperatively, accounting for the early presentation in two of the patients.