

may improve outcome without any obvious deleterious effects. But, on the basis of currently available evidence, uncertainty remains. Before widespread changes in practice are made this finding needs confirmation in a larger trial with mortality and major respiratory and cerebral morbidity as the primary outcomes.

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AUTHORS' REPLY.—We agree that umbilical cord clamping at preterm delivery warrants further study of large numbers of infants, including those delivered by caesarean section and those below 27 weeks' gestation. We believe that it is important to establish the management that results in optimal outcome for these infants and also to examine the complex mechanisms concerned, including blood volume changes and haemodynamic effects on systemic and pulmonary circulations.

With regard to the specific questions raised, there were no significant differences between the groups in maternal or obstetric histories. Onset of labour was spontaneous except in two cases in the regulated group, in which induction was performed for prolonged rupture of membranes. Suppression of labour was attempted with ritodrine in four cases in the regulated group and two cases in the random group; only one mother in each group received steroids antenatally. Oxytocin-ergometrine (Syntometrine) was given after delivery of the anterior shoulder except in the case of first twins (four in the regulated group and two in the random group). Uterine contractions before cord clamping and beat to beat variability in blood pressure were not recorded and would both be interesting in future studies. The policy regarding transfusion of red cells was as previously described¹; staff present at delivery could not be blinded to the treatment group but were seldom responsible for ordering transfusion.

Our results were analysed according to intention to treat. Only two infants could not be held as low as intended, and omitting these from analysis does not substantially alter the results. Both time and gravity are important in determining the volume and rate of placental transfusion.² Diana Elbourne is correct that the volume of placental transfusion received will contribute to the recorded birth weight; theoretically this could mean a difference of up to 6%. Reanalysis of our data, with the assumption that all infants in the regulated group received a placental transfusion of 50 ml/kg (probably a gross overestimate), showed no significant difference in weight between the groups, and results of stepwise regression analysis were not altered significantly.

We believe that a multicentre trial with clearly defined outcome measures is necessary to recruit an adequate number of premature infants. Investigation of physiological effects and analysis of outcome for infants in various categories will point to optimal management of cord clamping and

enable the establishment of practical guidelines. As June Alexander pointed out, the benefit of allowing foals a placental transfusion was established by veterinary specialists long ago.³

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Problem lists in letters

EDITOR.—As B W Lloyd and P Barnett emphasise,¹ communication between general practitioners and hospital specialists is of utmost importance—the letter remains the most significant factor in this and often it is this initial form of contact which may determine the care a patient receives and set the tune of the partnership between the two doctors. Although Margo concluded that general practitioners were generally satisfied with the initial outpatient letter,² most studies have found that communication between the hospital specialist and the general practitioner could be better.^{3,4} Defects which have been reported include absence of essential details, omission of information about treatment, no mention of what information has been imparted to the patient, and time delay.

It may now be time for the different royal colleges to examine the possible use of a standard hospital letter for all specialties to general practitioners. Such a proposal would allow all doctors, whether hospital based or in the community, to focus quickly on important areas—for example, medication prescribed; it would improve communication and reduce the risk of medical mishaps. It is highly embarrassing and totally inappropriate for doctors to shuffle through sheets of notes to locate one item of information while the patient sits waiting expectantly.

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- 1 Lloyd BW, Barnett P. Use of problem lists in letters between hospital doctors and general practitioners. *BMJ* 1993;306:247. (23 January.)
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EDITOR.—The short paper by B W Lloyd and P Barnett provides confirmation that problem list letters are welcome by their recipients,¹ but it should not be taken to imply that these are a new invention. I learnt their use in the early 1970s from Dr P B L Muldoon, physician at the North Staffordshire Hospital Centre, and have personally used them since 1974-5. They are, in various forms, routine practice for senior members in our department and, I am sure, many others.

They may also include several additional items of useful information: the duration of disease (for example, diabetes, malignancy) or date of operation, the certainty or otherwise of a diagnosis, the existence of an unexplained or undiagnosed symptom or sign, and involvement of other hospitals or carers. Others include a complete therapeutic list at the end, particularly useful with multiple drugs and forgetful patients. An example could thus be:

Insulin-treated diabetes with obesity (1971)
Active proliferative retinopathy (recent laser at Moorfields)
Diabetic nephropathy (biopsy proven, last creatinine 237 $\mu\text{mol/l}$)
Ischaemic heart disease (CABG 1991)
Unexplained low back pain
Recent bereavement
Current treatment:
Human Mixtard 24 units am, 16 units pm
Captopril 25 mg bd
Frusemide 40 mg mane
Aspirin 75 mg daily
Unknown analgesics

As the authors state, such letters are also of benefit to hospital clinicians, who can focus on the problems much more quickly than by scanning notes (often untidy or illegible) plus related correspondence and results. The subsequent familiarity with the problems is often welcome by the patient. To write such letters well does indeed require a critical review of the evidence.

There are other additional benefits. Copying of a single letter to all those involved in the care of a patient ensures that issues of overlap and interaction are less often overlooked. Such a recent letter, easily faxed, may provide sufficient data for an unfamiliar doctor or team to cope until notes are found, and if letters are stored as a cumulative file on a word processor a fairly complete history may easily be obtained from a secretary.

It is surely time that the old style of letter, "Your patient is doing well and should continue on the same treatment," was consigned to the history books. Few of us would be happy with a bank whose statements read "Your account is in credit but will not remain so for much longer."

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- 1 Lloyd BW, Barnett P. Use of problem lists in letters between hospital doctors and general practitioners. *BMJ* 1993;306:247. (23 January.)

EDITOR.—I entirely agree with B W Lloyd and P Barnett's view that a problem list in letters from hospital doctors to general practitioners is invaluable.¹ I have been using it for some years and encourage my junior staff to do the same. I believe that the general practitioners find a problem list more informative (although I have never investigated this formally) and that the copy letters in the notes make a more useful case summary than the handwritten record. I take the system further in that I split the text of the letter up into sections pertinent to each problem. The sample letter would therefore become:

Dear Dr Smith,
Re: John Jones 1.1.85
456 Any Street, London N17 33X

Problems:

1 *Poorly controlled asthma*—Thank you for referring this boy with frequent attacks of cough and wheeze. He sleeps badly and is short of breath on exertion. I was generally optimistic but emphasised the potential for serious attacks.

I prescribed sodium cromoglycate 10 mg (2 puffs) three times a day. His relief drug is terbutaline 1 mg (4 puffs) four hourly. Both are to be taken via a nebuliser (he has excellent technique).

His peak flow was 180 today and I have issued a peak flow meter for his parents to establish the best he can manage. I have given them the danger peak flow value of 100, and if it falls below this they will come to casualty.

2 *Passive smoking*—I have advised his parents to stop smoking as it is likely to be aggravating the child's asthma.

3 *Brother with Down's syndrome*—Close family involvement in the management of this child's asthma is important, and this will be less easy because of the care that his brother also needs.

4 *Poor housing*—I have not addressed this problem today.

Review—1 month.

I believe that this arrangement of letters is even easier to read and to scan for items of particular interest and relevance, both for the general practitioner and during further hospital follow up.

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EDITOR,—Problem lists in hospital letters¹ are an excellent way to improve communication, and they also enable quicker and more focused care for patients when they are reviewed at subsequent hospital appointments. I hope that general practitioners will increasingly use problem lists in their own letters.

There are two traps for the unwary. Firstly, the problem list can be overwhelmingly long if all the minor problems are included. It is often better to be selective or list the problems in order of priority. This tailors the list to the condition that is under review.

Secondly, there is a temptation to attach a diagnostic label to each condition so that it fits neatly on the problem list. This can lead to unquestioning acceptance of what is really a hypothetical diagnosis. It is better to use the symptom as "the problem" if the diagnosis is unclear.

My final point is a secondary issue relating to the sample letter. This was high quality until the last sentence, which suggested attendance at casualty if the peak flow fell. Surely in this fictional consultation the child's own general practitioner would be able to assess the child and administer inhaled or oral steroid as effectively, if not more effectively, than a busy house officer in a casualty department?

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The laryngeal mask

EDITOR,—Moirá E O'Meara and J Gareth Jones state that a laryngeal mask may prove life saving when a patient is impossible to intubate or ventilate by traditional methods.¹ One such incident occurred recently in our theatres. A young man underwent uvulopalatopharyngoplasty and trimming of inferior turbinates to prevent him snoring. After induction of anaesthesia tracheal intubation proved difficult owing to an anteriorly placed larynx (Mallampati grade II-III) and the patient's great size (he was 201 cm tall and weighed 118 kg). Once tracheal intubation had been achieved with the aid of a stylet, surgery proceeded

uneventfully. Two hours after the operation he developed a reactionary haemorrhage from the right tonsillar fossa and was returned to the theatre.

The bleeding into his pharynx was so massive that he was unable to maintain his own airway while lying supine. With the patient on his left side anaesthesia was induced with halothane in oxygen and small increments of propofol intravenously. The airway became increasingly difficult to maintain. Removing the nasal pack and inserting a nasopharyngeal tube did not improve matters. Direct laryngoscopy was performed and the posterior third of the larynx visualised, and suxamethonium was given to facilitate intubation. Several attempts to force the endotracheal tube over a gum elastic bougie were unsuccessful. Preparations were made to perform an emergency tracheostomy, but spontaneous respiration returned and a size 4 Brain laryngeal mask was inserted, allowing easy maintenance of the airway and confining further haemorrhage to the pharynx. There was adequate room to position a Boyle Davis gag into the oral cavity and control the tonsillar haemorrhage, and at the end of the procedure careful deflation of the laryngeal mask cuff under direct laryngoscopic vision allowed passage of an endotracheal tube into the trachea. The patient was transferred to the intensive care unit and was extubated the next morning.

Williams and Bailey recently described using a reinforced laryngeal mask for adenotonsillectomy.² We do not advocate routine use of a laryngeal mask in anaesthesia to control tonsillar haemorrhage as it does not guarantee protection from aspiration of blood and gastric contents.^{1,3} It can, however, be life saving when traditional methods of intubation fail, and we recommend its inclusion with equipment for difficult intubations.

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- 1 O'Meara ME, Jones JG. The laryngeal mask. *BMJ* 1993;306:224-5. (23 January.)
- 2 Williams PJ, Bailey PM. Comparison of the reinforced laryngeal mask airway and tracheal intubation for adenotonsillectomy. *Br J Anaesth* 1993;70:30-3.
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EDITOR,—Moirá E O'Meara and J Gareth Jones mention the life saving potential of the laryngeal mask when the patient is impossible to intubate or ventilate by traditional methods.¹ The mask is useful before the patient reaches hospital, particularly when ventilation is required in suspected cervical spinal injury and movement of the patient is minimised, and for facial injuries, in which using a face mask is difficult.² It can be passed when the operator is positioned in front of the patient, such as in a road traffic accident victim trapped in a vehicle, and the insertion technique is relatively simple and much less traumatic than endotracheal intubation.

Although the risk of aspiration has not been completely eliminated, massive regurgitation is unlikely to occur,³ but avoiding ventilatory pressures greater than 20 cm H₂O (not always practical in a trauma situation) avoids leaks around the cuff and minimises gastric dilatation. A I J Brain reported in an address to the Royal Society of Medicine that work is currently underway on developing a laryngeal mask that incorporates a separate channel through which a nasogastric tube can easily be passed.

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1 O'Meara ME, Jones JG. The laryngeal mask. *BMJ* 1993;306:224-5. (23 January.)

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EDITOR,—Moirá E O'Meara and J Gareth Jones comprehensively describe many aspects of the laryngeal mask pertinent to anaesthesia.¹ We would like to add comments about its use relevant to non-anaesthetists.

Although the laryngeal mask does not protect the airway against gastric contents, it has potential for use in resuscitation and emergency medicine when intubation is impossible and a patent airway cannot be maintained with a face mask. In this situation during anaesthesia the laryngeal mask has been life saving. Several studies have shown that unskilled staff rapidly acquire the skill to insert the mask.^{2,4} It is also important, however, to appreciate when attempts at insertion are inappropriate and to be able to recognise and manage failure of insertion. Studies are currently under way to determine the role of the laryngeal mask in emergency medicine and the degree of training required to ensure its safe application in this area. The laryngeal mask is being modified to produce a version that may afford better protection against aspiration,⁵ and this may extend its applications still further. These would include its use in emergency airway management in the field and in cervical spine injury as the neck may be maintained in the neutral position during insertion and laryngoscopy is not needed.

A further potentially widespread application is in diagnostic fiberoptic bronchoscopy in awake patients. The hypopharynx is well adapted to the presence of a foreign body, and insertion of the laryngeal mask can easily be achieved in awake patients under topical anaesthesia and sedation. When a fiberoptic bronchoscope is passed down the tube of the laryngeal mask a dynamic view of the vocal cords is possible in most patients.⁶ Bronchoscopy can be readily performed and has the added advantage of allowing the patient's respiratory function to be monitored and 100% oxygen to be administered if required.

We believe that formal training in the use of the laryngeal mask would be beneficial to any physician dealing with such cases. A laryngeal mask should be available in any hospital setting where airway management is carried out.

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- 1 O'Meara ME, Jones JG. The laryngeal mask. *BMJ* 1993;306:224-5. (23 January.)
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- 6 Brimacombe J, Newell S, Swainston R, Thompson J. A possible new technique for awake fiberoptic bronchoscopy—use of the laryngeal mask airway. *Med J Aust* 1992;156:876-7.

EDITOR,—We recently encountered an interesting complication related to use of a laryngeal mask.¹ After successfully excising a branchial cyst in the right neck the surgeon was faced with a deeper non-pulsatile cyst under considerable tension, with fine nerves and blood vessels traversing its wall. It was lying laterally between the greater cornu of the hyoid bone and the thyroid cartilage.