

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

An alternative view

SIR,—Several doctors have written recently complaining of uncaring or inefficient treatment sustained by themselves or their relatives in intensive care units. To restore some sense of balance I want to record the exemplary care and technical efficiency shown by the staff in two separate intensive care units, which resulted in my 15 year old grand-daughter's life being saved.

In May, while she was cycling, the front wheel of her bicycle entered a roadside rut and she was thrown into the slipstream of a passing lorry. A neighbouring general practitioner accompanied her, dyspnoeic and semiconscious, to the Royal Berkshire Hospital, Reading. She nearly died in transit, had a cardiac arrest in casualty, and had lost so much blood that after transfusion a laparotomy was necessary to exclude a ruptured spleen. The massive haemorrhage had come from both lungs, which had many perforations. Ventilation kept her lungs functioning, and with the help of sedatives, muscle relaxants, and bilateral chest drains she made slow progress. Fresh pneumothoraces occurred, however, her lungs became inadequately oxygenated, and the consultant anaesthetist told her parents that she would die unless transferred to the Brompton Hospital with its unique facilities. Owing to the risk of death in transit, the consultant made detailed arrangements and despite being off duty accompanied her to the Brompton Hospital. On arrival the consultant physician assessed her chance of survival as being merely 10%. She was ventilated with the most modern ventilator, which delivered oxygen at 420 impulses/minute, and survived three episodes of extreme danger during the subsequent 10 days without needing a heart-lung transplant.

The medical registrar in charge of day to day care of the unit visited her several times while off duty, and the consultant physician, anaesthetist, and thoracic surgeon were equally caring and efficient.

Eight weeks after the accident my grand-daughter was taken off the critical list and is now rapidly approaching full health, albeit with slightly damaged lungs. Throughout the danger period her parents were kept fully briefed about her condition and the reasons for changes in treatment; a royal person could not have received better care.

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Epidural anaesthesia in obstetrics

SIR,—An otherwise fascinating editorial by Dr Felicity Reynolds¹ was spoiled by a few but important flaws which must not go unchallenged.

She asserts, as do most anaesthetists, that epidural analgesia is not associated with an increased incidence of forceps delivery, and of course she quotes papers, most of which were published in anaesthetic journals, to support her view. I believe that I am correct when I say that most obstetricians, though very much in favour of epidural analgesia, hold the view that the incidence of assisted delivery is increased by its use; it is possible to quote published reports supporting this view.^{2,4} It is probably impossible to design a prospective trial of matched, contemporaneous deliveries today to resolve the controversy. This is an important issue and reflects most women's concerns when they choose pain relief in labour.

I also take issue with Dr Reynolds when she suggests that eclamptic fits are less likely to occur with "good analgesia." I accept that epidural anaesthesia aids the management of hypertension in labour, but eclamptic fits are prevented by adequate prophylactic treatment with anticonvulsant drugs.

Finally, it is misleading to suggest that "a patient with an epidural block can be made ready for emergency surgery remarkably quickly." The routine epidural administered for pain relief in labour is inadequate for, say, caesarean section. "Topping up" the epidural for caesarean section often takes at least 20 minutes—this would obviously be unacceptable in cases of fetal distress.

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- 1 Reynolds F. Epidural anaesthesia in obstetrics. *Br Med J* 1989;299:751-2. (23 September.)
- 2 Buxton EJ, Redman CWE, Obhrai M. Delayed pushing with lumbar epidural in labour. *J Obstet Gynaecol* 1988;8:258-61.
- 3 Crawford JS. The effect of epidural block on the progress of labour. In: Studd JWW, ed. *Progress in obstetrics and gynaecology*. Edinburgh: Churchill Livingstone, 1982:85-93.
- 4 Smith ARB, James DK, Faragher EB, Gillfillan S. Continuous lumbar epidural analgesia—does delayed pushing in the second stage reduce the incidence of instrumental delivery? *J Obstet Gynaecol* 1982;2:170-2.

AUTHOR'S REPLY.—I thank Mr Manyonda for his interest in my editorial, but I am sorry that he considers it flawed. The required brevity of an editorial necessitates its careful reading. I did not state, still less "assert," that epidural analgesia is not associated with an increased incidence of forceps delivery. I can even quote a reference of my own¹ that it may be. My words were, "With appropriate management introducing an epidural service need not increase the incidence of forceps delivery," and the reference I quoted¹ bore this out. As I stated, because mothers who might have instrumental delivery anyway are overrepresented in those receiving epidural analgesia, data as commonly presented are misleading.

I would not agree, however, that it is impossible

to design a prospective trial to resolve the controversy. Rather it is impossible to conduct one, for ethical and humanitarian reasons, and few women would consent to take part. The correct solution to this endless debate is to examine the impact on the overall rate of forceps delivery in a given population when an epidural service is introduced. It is rarely possible to do this, but it was done in Doncaster, where Bailey and Howard showed that a rise in the rate of epidural analgesia from 0% to 43% was not associated with a change in the overall rate of forceps deliveries.² If, with all the experience accumulated since Doughty³ first showed the way out of the problem, we are unable to emulate his and the Doncaster experience, then we should question whether our management of the second stage is always appropriate.

I hardly need defend myself for suggesting that fits are less likely with good analgesia, and the reference I cited⁴ bore out this commonsense idea. I did not suggest that analgesia eliminated the need for anticonvulsant treatment when indicated.

As to the speed with which a woman with an epidural catheter in situ may be prepared for caesarean section, this is a matter of experience. Epidural blockade sufficient for analgesia in labour is adequate for a Pfannenstiel incision, and if as soon as the anaesthetist is called he or she gives additional local anaesthetic then the block will extend sufficiently during shaving, insertion of the catheter, and, if necessary, positioning on the operating table to cover the later stimuli from opening the peritoneum and traction. Though anaesthetists may say that they do not allow surgery to proceed until the sensory block extends to T4, I do not let such strictures govern my own practice in the presence of fetal distress if I am extending an already effective block. And to anticipate the next angry letter: no, I have not yet found it necessary to give general anaesthesia in mid-surgery. Moreover, what obstetrician has not stood by, inwardly fuming, while a patient is prepared for general anaesthesia? The procedure is not instantaneous; time is saved when epidural analgesia is used, and it is safer for the mother. Extending the epidural block for a forceps delivery can be time consuming and irksome, particularly when it has been allowed to wear off during the second stage in the mistaken idea that this will promote normal delivery.

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- 1 Walton P, Reynolds F. Epidural analgesia and instrumental delivery. *Anaesthesia* 1984;139:219-23.
- 2 Bailey PW, Howard FA. Epidural analgesia and forceps delivery: laying a bogey. *Anaesthesia* 1983;38:282-5.
- 3 Doughty A. Selective analgesia and the forceps rate. *Br J Anaesth* 1969;41:1058-62.
- 4 Moir DD, Victor-Rodrigues L, Willocks J. Epidural analgesia during labour in patients with pre-eclampsia. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 1972; 79:465-9.