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A copy of this letter was sent to Dr Seymour, whose reply follows:

Sir, The points raised by Gillman and Lichtigfeld are dependent upon intravenous administration of dihydrocodeine producing supratherapeutic plasma concentrations. There does not appear to be any information on the comparative plasma concentrations of dihydrocodeine after either intramuscular or intravenous administration. In our study dihydrocodeine was given via the intravenous route to try and achieve optimal analgesia in patients with postoperative dental pain (Seymour *et al.* 1982). We have previously shown that dihydrocodeine undergoes extensive first-pass metabolism when given orally (Rowell *et al.* 1983).

The precise mechanism of dihydrocodeine-induced hyperalgesia in postoperative dental pain remains uncertain. The explanations suggested by Gillman and Lichtigfeld were, in part, put forward in our original paper. Perhaps the issue can be resolved by further studies evaluating dihydrocodeine (via different routes of administration) in patients with postoperative dental pain.

R A SEYMOUR
29 April 1985

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Pancreatic pleural effusion with normal serum amylase levels

*From Dr Alexander K C Leung
Alberta Children's Hospital
Calgary, Alberta, Canada*

Sir, Ascites was first recognized as a complication of pancreatitis in the early 1950s (Davis & Kelsey 1951, Smith 1953). It was not until the last decade that pleural effusion was recognized as a complication of chronic pancreatitis (Cameron 1976). In most cases, serum amylase levels were elevated (Sankaran 1976). I report a child with pancreatic pleural effusion with normal serum amylase levels.

A 13-year-old girl had had severe abdominal pain on and off since the age of 5. This was sometimes associated with bilious emesis. Three months prior to admission, she developed ascites and a large left-sided pleural effusion. She was very active in gymnastics but she could not recall any

history of trauma. Serum amylase levels were 33, 50 and 34 U/l on various occasions. The left hemithorax fluid and the ascites fluid had amylase levels of 584 and 898 U/l respectively.

This report suggests that although serum amylase levels are usually elevated in patients with pleural effusion secondary to chronic pancreatitis, normal levels cannot exclude such a possibility.

ALEXANDER K C LEUNG
25 March 1985

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Confidential enquiry into perioperative deaths

From Mr Brendan Devlin

*Secretary to the Joint Working Party of the
Confidential Enquiry into Perioperative Deaths*

Sir, A project to enumerate death rates within 30 days of surgical operations and to identify remediable factors in the practice of anaesthesia and surgery, has been initiated by the Association of Surgeons of Great Britain and Ireland and the Association of Anaesthetists of Great Britain and Ireland. The project has the support of the Surgical Royal Colleges, the Royal College of Obstetricians and Gynaecologists and the Faculties of Anaesthetists, and many other professional organizations are giving backing and advice. The study is funded by the Nuffield Provincial Hospitals Trust and the King Edward's Hospital Fund in London.

The study is a major new initiative within the surgical and anaesthetic professions. It is voluntary, but hopefully there will be 100% participation by the initial three study regions—the Northern Region, the South Western Region and the North East Thames Region. The study is fully confidential, but one novel feature is that there will be a system of feedback to participating individual clinicians so that they can obtain the opinions of the assessors in each death they report.

The study is to be managed by a Joint Working Party with Professor M D Vickers as Chairman. Professor J S P Lumley, Dr J Lunn and myself have been appointed the Clinical Co-ordinators to organize the day-to-day clinical activities of the study. Further information and copies of the detailed protocol are obtainable from: Mr Nigel Buck, Administrator, CEPOD, 14 Palace Court, London W2 4HT.

H BRENDAN DEVLIN
9 April 1985