LETTERS TO THE EDITOR

POSTOPERATIVE SORE THROAT

DEAR SIR,

Like Dr. Cozanitis I too have followed the various communications in your journal concerning the causation of postoperative sore throat.

Many years ago I took an interest in this subject and was surprised to discover in conversation with patients after operation that sore throats were often unilateral or if not unilateral at least worse on the right than on the left. I am sorry that at the distance of some twenty years I cannot produce figures to substantiate this statement, but I can add one observation which I think is of significance; on some occasions during intubation of a patient I noticed the anterior pillar of the fauces being put under considerable tension during laryngoscopy, which of course a right-handed anaesthetist performs by sweeping the patient's tongue to the left. On one occasion in particular I actually saw this stretched anterior pillar of the fauces break with solution of the continuity of the mucous membrane of the pharynx at this point. These experiences suggested to me that there was a considerable pharyngeal content to postoperative sore throat. A point which is also emphasized by the fact that such discomfort, like that following tonsillectomy can be largely relieved by the administration of aspirin mucilage or even the sucking of a couple of aspirin tablets.

I hope this brief communication will encourage someone who has the facilities to look more fully into this particular aspect of this complication.

Yours faithfully,
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CASTOR OIL AND DRUG ABSORPTION

DEAR SIR,

We read with great interest, the paper by Gwilt, *et al.*¹

In the Proceedings of the Annual Meeting of the American Academy of Clinical Toxicologists,² we reported an experiment precisely similar to that described by the authors and with exactly similar results.

However, our conclusions differ. We felt that the experiment simply showed that no dialysis of the drug occurred back into the gut.

The ligand theory remained to be tested and this was done using coma induced by ethchlorvynol and subsequently treated with supportive care alone, supportive care plus enteric castor oil, supportive care plus mineral oil and supportive care plus phenolphthalein.

A reduction of coma time by 60 per cent was demonstrated in the dogs having either oil added to the treatment regimen. Elimination half lives also showed a significant reduction when either oil was used. No reduction was seen with simple catharsis.²

Unfortunately, we were not able to extract as much information from our original data as Gwilt, *et al.* have done. We would not be prepared to state that ethchlorvynol absorption continues for 30 hours in our untreated group or 15 hours in our treated group³ as they have stated. The authors also go on to suggest using data points after these times to establish Beta slopes. We suggest that two or three data points are inadequate for an acceptable correlation coefficient and any further conclusions based on such a slope would be open to error.

In fairness to the authors, it should be admitted that we were not entirely accurate in our 1976 discussion and only after subsequent experimental work were we convinced of the ligand effect of castor oil and were able to report this in detail in 1980.

In the clinical setting we have not seen an overdose coma caused by lipophilic drugs last over 48 hours in our ICU since the addition of the castor oil routine some ten years ago.

Sincerely,
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