ume teaching unit, on a regular basis, in order to maintain their expertise and to learn new techniques.

The second concern relates to the management of potential complications when an anaesthetist may not be physically present. This concern also relates to higher volume units where the anaesthetist may be "tied up" in an operating room with a surgical case. In fact the guidelines actually contain the answer in that they state that "an appropriate protocol for the management of these epidurals is in place."¹

I would suggest that the setting up of these protocols is the most important aspect of this document. It is essential that the nurses caring for these parturients be educated in the recognition of complications and their initial management. This education, in the low-volume units, must not be a one-time event. It should be repeated and reemphasized at regular intervals. Additionally, other physicians who might be physically present in the hospital should be educated and trained in the management of these complications. This would include obstetricians, family and emergency physicians.

The other recommendation is that all hospitals practicing obstetrics should have a regular program of CPR training with emphasis on the parturient.³ The importance of uterine displacement in critical situations may not be recognized unless specifically included in the protocols. The normal response to finding a hypotensive, apnoeic patient is to place him/her supine in the Trendelenburg position. This could prove fatal in the parturient.

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Anaesthesia and myasthenia gravis

To the Editor:

I was disappointed that the comprehensive review article by Baraka¹ made little or no mention of the benefits of

combined regional/general anaesthesia in these patients. Although Dr. Baraka pointed out that the use of regional or local anaesthesia "seems warranted in these patients," he did not expand on this concept when discussing the management of retrosternal thymectomy.

A thoracic or high lumbar epidural anaesthetic in combination with balanced general anaesthesia provides excellent analgesia both intraoperatively and during the period following the thymectomy.² This decreases the stress response to the sternotomy, decreases opioid requirements and perhaps even the dose of neuromuscular blocking agents. This in turn allows these patients to meet extubation criteria earlier and in some individuals prevents the need for postoperative ventilation.

The current trend for anaesthetists to emphasize aggressive pain management,³ not only for aesthetic reasons, has seemed to miss a beat in this article. I hope this letter may perhaps remind readers of the obvious benefits of a combined regional/general anaesthetic technique, using an indwelling epidural catheter for retrosternal thymectomy.

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REPLY

Thank you for referring to me the letter of Dr. Gambling. I agree with him that thoracic or simply high lumbar epidural analgesia using local anaesthetic and/or narcotic, in combination with a balanced general anaesthesia, provides excellent analgesia both intraoperatively and postoperatively. The benefits of this combination are not limited to myasthenic patients undergoing thymectomy¹ but also apply to other patients undergoing any thoracic² or major abdominal and vascular surgery.³ However, the concept is still controversial.⁴ Many of our patients do not accept the idea of having a needle or a catheter in their "back" as a modality for pain relief. Also, because of the possible delayed respiratory depression, all patients having epidural morphine must be observed in an ICU setup for at least 12-24 hr post-operatively.

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