quoted as being 0.31%. This represents the risk where the patient was symptomatic. It probably exaggerates the risk where the patient is HIV positive but not symptomatic because infectivity probably depends on the titre of virus and the volume of blood transmitted. The titre of virus is much lower in asymptomatic HIV positive patients than in those with AIDS.

Routine testing after needle stick injuries need not identify the patient by name. The name of the health care worker can be used to identify the specimen, thus protecting the confidentiality of the patient. The cost of such testing would be worthwhile because useful data would be gathered and individuals who sustain needle stick injuries would have the benefit of knowing the risk they have incurred, allowing them to take appropriate precautions and be appropriately treated.

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REFERENCE

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Glass ampoules

To the Editor:

Most anaesthetists open dozens of glass ampoules each week. The quality of the scoring varies with ampoule. Some, notably Diprivan (propofol) and Lidocaine 20 ml ampoules break with difficulty, often resulting in lacerations of the thumb and forefinger.

Therefore, we have devised a simple, readily available device for opening large glass ampoules (see Figure). The end of an 8.5 oral endotracheal tube is cut off to include the adapter. The neck of the ampoule is inserted into the endotracheal tube adapter and snapped smartly, thereby opening the ampoule and avoiding injury should it shatter at the neck. The broken end of the ampoule will then drop out with a gentle shake, or can be pushed out with a stylet.

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FIGURE

Continuous intercostal nerve block following thoracotomy

To the Editor:

We read with interest the paper by Chan *et al.* (Can J Anaesth 1991; 38: 733–9) and would like to comment on the technique and update your readers regarding our quoted paper.

We have recently demonstrated by contrast computed tomography that the site of action of continuous extrapleural intercostal nerve block was in the paravertebral space.¹ Paravertebral block not only affects the intercostal nerves more effectively due to their lack of fascial sheath but also blocks the posterior primary rami which mediate pain from straining of the ligaments of the costovertebral and costotransverse joints and the posterior spinal muscles. By placing the catheters 7–8 cm lateral to the vertebral column, Chan *et al.* would have missed the posterior primary rami. This may explain the lower efficacy of their technique.

Placing the catheter in the paravertebral space² obviates the need for more than one catheter since the spread of anaesthetic agent averaged six intercostal spaces.¹ This technique has also been demonstrated to be effective after pleurectomy with preservation of the parietal pleura overlying the paravertebral space.³ The breach of pleura following most routine thoracotomy should not exclude its application.

Chan *et al.* criticised our original pilot study⁴ for not recording the pain scores. Our randomised, prospective, double-blind study has confirmed the efficacy of continuous intercostal nerve block after thoracotomy not only in reducing pain scores but also in aiding postoperative recovery of pulmonary functions.⁵ This leads to a reduction of postoperative pulmonary complications after