REFERENCES

- 1 Smith JD, Bia MJ, DeFronzo RA. Clinical disorders of potassium metabolism. In: Arieff AI, DeFronzo RA (Eds.). *Fluid, Electrolyte and Acid-Base Disorders*. New York: Churchill Livingstone Inc. 1985: 413-509.
- 2 Sellevold O, Breivik H, Tveter K. Changes in oncotic pressure, osmolality and electrolytes following transurethral resection of the prostate using glycine as irrigating solution. *Scand J Urol Nephrol* 1983; 17: 31-6.
- 3 Hahn RG, Berlin T, Lewenhaupt A. Factors influencing the osmolality and the concentrations of blood haemoglobin and electrolytes during transurethral resection of the prostate. *Acta Anaesthesiol Scand* 1987; 31: 601-7.
- 4 Norten H, Allgen LG, Vinnars E, Bedrelidou-Classon G. Glycine solution as an irrigating agent during transurethral prostatic resection. *Scand J Urol Nephrol* 1986; 20: 19-26.

Cuff tears: can they be prevented?

To the Editor:

The nasotracheal route is usually utilized in patients selected for awake tracheal intubation. Damage to the nasal mucosa, the turbinates and the nasopharyngeal wall during nasotracheal intubation has been well described. Damage to the tube cuff is a frequent finding, especially when resistance is encountered during passage of the tube; this may necessitate reintubation over stiff plastics, gum bougies or woven stylets with no guarantee that the new cuff will not encounter a similar fate.

We have used a well lubricated Penrose drain, introduced into the nasal cavity, as a shield between the nasal structures and the advancing tube. An angulated forceps is used to insert the drain which is stabilized with two mosquito forceps. The endotracheal tube is inserted through the nasal cavity inside the Penrose drain (Figure).

FIGURE Endotracheal tube inserted inside Penrose drain.

After successful intubation, the Penrose drain is left *in situ* and is removed, together with the endotracheal tube, at the end of the surgical procedure.

We believe that the technique is beneficial in many patients, especially those with a difficult airway.

S. B. Backman MD PhD
M. Abou-Madi MD FRCPC
D. Trop MD FRCPC
Montreal Neurological Hospital
Montreal

Pain relief in labour

To the Editor:

"Giving an anaesthetic and not seeing the patient post-operatively is like doing an experiment without bothering to read results."* Yet, so few anaesthetists see their patients after anaesthesia. Small wonder that many of our patients complain despite our "best efforts."

Obstetric anaesthesia is a special situation. Pain in labour is one of the most severe forms of pain and, moreover, it occurs in those whom we love most.¹ We started an epidural service in 1957. Recently, we evaluated the efficacy of our technique in 65 parturients. All were healthy and at term. After a test dose of 2 ml, 2% lidocaine HCl, 10 ml 0.25% bupivacaine or 10 ml 0.25% bupivacaine were injected with 1 $\mu\text{g} \cdot \text{kg}^{-1}$ fentanyl. Demographic data were collected (Table) and the patient followed by an independent observer. Assessment was by Visual Analogue Scales (VAS) 20 min after epidural initiation, and then every hour until delivery, and again between 12 to 24 hr post delivery. Our results are presented in the Figure. The group of patients receiving bupivacaine and fentanyl mixture required fewer top-ups for the first two hours after the epidural was started.

Twelve to 24 hours after delivery we asked the patients to classify the quality of their pain relief during labour, during pushing, and during delivery as excellent, very good, good, fair and poor. Ninety-eight percent of women described their pain relief as good to excellent during labour, 74% as good to excellent during pushing and 94% as good to excellent during delivery.

Our audit confirmed the clinical impression that most patients were satisfied. We encourage other anaesthetists to do similar audits. It is the simplest and best way of

*Personal communication, James Parkhouse.