Correspondence

Epidural analgesia in children

To the Editor:

I acknowledge that it is unusual for an author to respond to an editorial concerning his publication; however, there is one inaccuracy in Dr. Berde's editorial¹ which should be corrected.

In the editorial entitled "Epidural analgesia in children," Dr. Berde¹ states that we compensate for the lack of an anaesthetist in hospital at night "by confining patients to Intensive Care areas and relying on acute response to emergencies by the paediatric residents and paediatric intensivists." In our manuscript we stated "All children who had epidurals *in situ* were nursed in one of several designated wards where the nursing staff have received training in the management and complications associated with epidural infusions." We presently provide epidural analgesia service in intermediate care areas and on wards, and monitoring requirements for patients are established according to the special needs of each individual patient.

Because there is an obvious difference between the standard of care we provide and the interpretation of statements in our manuscript by Dr. Berde, it is important that this issue be clarified for readers of the journal.

Gerald V. Goresky – Director
Department of Anaesthesia
Alberta Children's Hospital

REFERENCE

- 1 Berde C. Epidural analgesia in children (Editorial). *Can J Anaesth* 1994; 41: 555–60.

Did you have anything to eat, drink or, maybe, chew?

To the Editor:

Policies concerning preoperative fasting have been modified with changes in anaesthesia practice. At present, it is considered acceptable to administer medications with a "sip of water" prior to induction of anaesthesia. If not swallowed, the pills may cause either obstruction of the oral airway,¹ or the endotracheal tube.² Pills can also create a risk for aspiration by adhering to a laryngeal mask airway.³ As these reports were described in elderly

and/or neurologically compromised patients,^{1–3} the liberal practice of taking preoperative oral medications should be reconsidered in this patient population, and the administration should be appropriately modified. In contrast, we describe two cases of oriented and well-educated patients who violated the "nothing by mouth" policy, and, at the time of anaesthetic induction, had chewing gum in their mouths.

A 35-yr-old female registered nurse underwent laparoscopic surgery. At the end of uneventful general anaesthesia the orogastric tube was pulled out, and a yellow sticky substance was found along its side. The patient subsequently admitted to having chewing gum (yellow) in her mouth prior to induction of anaesthesia. The chewing gum had been introduced into the oesophagus during orogastric tube placement.

A 15-yr-old boy was admitted for arthroscopy. After induction of anaesthesia with thiopentone a Guedel airway was inserted and uneventful inhalational anaesthesia was administered with a face mask. Following completion of anaesthesia, the airway was removed and chewing gum was found attached to its convex surface.

These two cases illustrate the importance of thorough preinduction interrogation about the fasting status, and the usual question: "Did you have anything to eat or drink?" should be expanded to "Did you have anything to chew?"

Juraj Sprung MD PhD
Santosh Kalhan MD
Walter Maurer MD
The Cleveland Clinic Foundation
Department of General Anesthesiology, M-26
9500 Euclid Avenue
Cleveland, OH 44195-9247

REFERENCES

- 1 Walker MB. An unusual destination for oral premedication (Letter). *Anaesthesia* 1994; 49: 839.
- 2 Murray DP, Wait CM. Whatever happened to the premedication? (Letter) *Anaesthesia* 1993; 48: 269.
- 3 Cairo SA. An unusual result of using a laryngeal mask airway (Letter). *Anaesth Intensive Care* 1994; 22: 231.

Trans-tracheal jet ventilation

To the Editor:

I am disappointed to read that percutaneous trans-