monkeys with human *H. pylori*.^{3,4} We considered that when *H. pylori* infection is initiated or aggravated, the IgG level would increase even at an interval of four weeks. The present results nearly deny this hypothesis. Although the measurement of this IgG has high sensitivity, it is only a screening test, suggesting that further more-extended studies involving other indices of *H. pylori* infection are needed.

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Anaesthesia preadmission assessment using a screening questionnaire

To the Editor:

We read with interest this report on preoperative assessment. It is with some dismay that we note that in this approach an assessment by an internist is the chosen method for same day admission cases.

This implies that the anaesthetist is less adequately trained or skilled in preoperative assessment than is the internist and considerably weakens our role as perioperative physicians. Such an approach can only potentiate the impression that we function as intraoperative technicians and could be detrimental to the perspective of our specialty among other members of the medical profession.

The authors note that the adequacy of assessment

was comparable to that of a report based on assessments by anaesthetists only.¹ Consequently, it is unclear to me what can be gained by delegating this aspect of our practice to another speciality.

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REPLY

We thank Dr. J. McChesney for his interest.¹ We do not agree that our approach delegates preoperative assessment to internists and relegates anaesthetists to "intraoperative technicians".

Our approach is that patients are not routinely seen by either an anaesthetist or an internist. Instead, whether they are seen is based on a questionnaire response or on request by the surgeon or patient. For patients for "same day admission" procedures, the internist is the initial physician involved with preoperative assessments when required. As postoperative medical management is directed by the internists at our institution, they believe that, to provide competent postoperative assessment and care, it is important to see patients before surgery. The Department of Anaesthesia believes that we need to see patients preoperatively when preoperative assessment and management will alter the intraoperative course, e.g. (malignant hyperthermia, airway abnormalities).

For surgical outpatients, the anaesthetist is the primary physician involved with preoperative assessments as there is no planned in-hospital postoperative care. This group of patients is now undergoing more major procedures (e.g. laparoscopic cholecystectomy, anterior cruciate ligament repairs) and more frequently includes patients who may have significant co-existing disease.

Our method allows patients to be assessed preoperatively by the appropriate physician using a collaborative approach between anaesthesia and internal medicine. This process led to appropriate assessments 84% of the time as determined by the attending anaesthetist on the day of the procedure.

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Rosemary A. Craen
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through use of a screening questionnaire. *Can J Anaesth* 1998; 45: 87-92.

Potentially incorrect terminology-lumbosacral plexopathy

To the Editor:

Crosby *et al.* present a case of permanent neurological dysfunction following abdominal aneurysmectomy and attribute it to a lumbosacral plexopathy caused by an iliopsoas haematoma.¹ I agree with the authors that there is sufficient reason to believe that the iliopsoas haematomas are at least partially responsible for the deficits seen in the femoral and lateral femoral cutaneous nerves (i.e. lumbar plexus). Their conclusion is supported by the extensive literature review they present and by a review of the relevant anatomy. However, I believe that they should refer to the observed neurological dysfunction as a lumbar plexopathy. There is little reason to believe that the iliopsoas haematoma is responsible for deficits seen in the distribution of the "entire" sciatic nerve. While the lumbosacral "trunk" (technically a part of the lumbar plexus at the level of the pelvic brim) may, in theory, be compressed by a large psoas haematoma, it is extremely unlikely that the rest of the sacral plexus would be affected in like manner. The deficits in the sacral divisions of the sciatic nerve (sacral plexus) likely have an alternative explanation as suggested by the authors (i.e. vascular compression or vessel rupture). Therefore, I believe that the latter should be referred to as a sacral plexopathy to avoid confusion and that the combined terminology "lumbar and sacral plexopathy" be used to emphasize the disparate etiologies for the two pathological entities - especially as the aetiology of the sacral plexopathy is unclear!

Dr. Scott A. Lang
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Haemodynamic effects of adding ephedrine to propofol and alfentanil

To the Editor:

One important problem during induction of anaesthesia with propofol is hypotension.¹ Preinduction

vagolytic agents have been used in an attempt to overcome it.^{2,3} Recently, the haemodynamic outcome of adding ephedrine to propofol during induction was studied⁴ but the effect of intubation was not evaluated.

In a randomised double-blind study in 54 healthy ASA Class I patients, we investigated the haemodynamic effects of adding graded doses of ephedrine (20 mg or 30 mg *iv* vs placebo) to 20 ml propofol 1%. The anaesthetic induction sequence was standardised using 2 mg·kg⁻¹ propofol and 20 µg·kg⁻¹ alfentanil. Vecuronium (0.15 mg·kg⁻¹) was used to facilitate tracheal intubation and anaesthesia was maintained with infusion of propofol and alfentanil mixture (50 µg·ml⁻¹) at 1 ml·kg⁻¹·hr⁻¹.

Decreases in heart rate and systolic blood pressure were observed in the placebo group, but not in either treatment group, following induction of anaesthesia. However, modest increases in systolic blood pressure and heart rate were observed in response to tracheal intubation in both treatment groups. Ephedrine 20 mg when added to 20 ml propofol 1% provided the better haemodynamic profile. (Figure)

Although the addition of ephedrine to propofol and alfentanil may prevent the decrease in blood pressure after induction of anaesthesia, it caused an increase in heart rate and systolic blood pressure after intubation. Whether this results in increased cardiac morbidity in patients with coronary artery disease is unknown, but caution should be taken when administering ephedrine with propofol.

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FIGURE Median (range) of the haemodynamic variables at baseline (0), after induction (D) and intubation (T) using propofol 1% (○), 20 mg ephedrine in 20 ml propofol 1% (□) or 30 mg ephedrine in 20 ml propofol 1% (●).

* $P < 0.05$ vs baseline value.

† $P < 0.05$ vs baseline and the other two Groups.