the type of surgery. However in young patients in our study,¹ the catheter tip sometimes goes straightly cephalad and this might make the epidural block inadequate. When it is necessary to locate the catheter tip at a specific level, we suggest using x-rays to confirm catheter tip position even if the Arrow Flex Tip Plus™ catheter is used.

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Reference

- 1 Hoshi T, Miyabe M, Takahashi S, Toyooka H. Evaluation of the Arrow Flex Tip Plus™ epidural catheter tip position and migration during continuous thoracic analgesia (Letter). Can J Anesth 2003; 50: 202–3.

General anesthesia and simulator driving skills

To the Editor:

I would like to commend Sinclair *et al.*¹ on their recent article but take issue with certain points.

In their introduction they quote Kortilla's² work from 1977 and state no one has addressed fitness to drive following newer anesthetics. In 2000, we published two papers in the British Journal of Anesthesia. The first addressed the issue of using alcohol as a comparator for recovery from anesthesia³ and the second examined recovery after propofol.⁴

In Sinclair's study mean $\pm$ 2 SD alcohol concentration ranges widely from 0.061 to 0.097% blood alcohol concentration (BAC). We also found a wide range of BAC using the oral dose and suggested an *iv* infusion to reduce this. At lower alcohol concentrations we found a similar impairment to Sinclair.

The use of a driving simulator is to be applauded but a lack of real life applicability can be seen when before alcohol the subjects had a mean of two crashes in a short 20 min run. This does not appear to be a real-life simulation.

Previous investigators demonstrated impairment in psychomotor performance for four postoperative days.⁵ Should driving be banned until psychomotor performance on all tests returns to normal? It could be argued that a small degree of impairment, similar to that seen with a BAC of 0.02% (or propofol 0.2 $\mu\text{g}\cdot\text{mL}^{-1}$) would be acceptable to drivers. The impair-

ment seen at this level must be compared with that measured in patients receiving antidepressants or antihistamines. This is an issue that needs full and widespread debate.

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References

- 1 Sinclair DR, Chung F, Smiley A. General anesthesia does not impair simulator driving skills in volunteers in the immediate recovery period - a pilot study. Can J Anesth 2003; 50: 238–45.
- 2 Kortilla K, Tammisto T, Ertama P, Pfaffli P, Blomgren E, Hakkinen S. Recovery, psychomotor skills, and simulated driving after brief inhalational anesthesia with halothane or enflurane combined with nitrous oxide and oxygen. Anesthesiology 1977; 46: 20–7.
- 3 Grant SA, Millar K, Kenny GN. Blood alcohol concentration and psychomotor effects. Br J Anaesth 2000; 85: 401–6.
- 4 Grant SA, Murdoch J, Millar K, Kenny GN. Blood propofol concentration and psychomotor effects on driving skills. Br J Anaesth 2000; 85: 396–400.
- 5 Flatt JR, Birrell PC, Hobbes A. Effects of anaesthesia on some aspects of mental functioning of surgical patients. Anaesth Intensive Care 1984; 12: 315–24.

Propofol 2% in two different oil-in-water emulsions: a randomized, double-blind study

To the Editor:

We evaluated two different propofol 2% formulations, a mixture of medium-chain and long-chain triglycerides (LCT/MCT propofol) and LCT propofol 2% in terms of hypnotic efficacy,¹ pain on injection anesthesia^{2–4} and development of hypertriglyceridemia.⁵

Fifty-nine patients were scheduled for thoracic surgery and prospectively randomized to receive one of the propofol formulations in a double-blinded protocol. Primary study variables were average propofol necessary to maintain a bispectral index (BIS) value of $\leq$ 45, hemodynamic effects, evaluation of pain on injection and serum triglycerides concentration.

After premedication with 7.5 mg of oral midazolam, an *iv* cannula (16-gauge) was placed in the dorsum of the hand, anesthesia induced with 3 $\mu\text{g}\cdot\text{kg}^{-1}$ fentanyl and 2 $\text{mg}\cdot\text{kg}^{-1}$ of propofol. Following a very slow injection by hand the application was stopped after 60 mg and assessment of pain (five-point scale)