context of the clinical situation, may not be as "nonsensical" or difficult to understand as Dr. O'Sullivan might suggest.

Donald R. Miller MD FRCPC
Raymond J. Martineau MD FRCPC
Department of Anaesthesia
Ottawa General Hospital
University of Ottawa
Ottawa, Ontario

REFERENCES

1 *Miller DR, Martineau RJ.* Bolus administration of esmolol for the treatment of intraoperative myocardial ischaemia. Can J Anaesth 1989; 36: 593–7.
2 *Gobel FL, Nordstrom LA, Nelson RR.* The rate pressure product as an index of myocardial oxygen consumption during exercise in patients with angina pectoris. Circulation 1978; 57: 549–56.
3 *Cokkinos DV, Voridis EM.* Constancy of rate-pressure-product in pacing induced angina pectoris. Br Heart J 1975; 38: 39–42.
4 *Buffington CW.* Hemodynamic determinants of ischemic myocardial dysfunction in the presence of coronary stenosis in dogs. Anesthesiology 1985; 63: 651–2.

Anaesthesia and medico-legal concerns[1]

To the Editor:

It is now becoming more obvious that proper communication with the patient is an essential component in the provision of complete medical care. This issue is raised and further discussed in the above editorial. Throughout my career as an anaesthetist, it had always been my feeling that the preoperative visit made to the patient in hospital, the evening before surgery, was generally equally unsatisfactory to both patient and anaesthetist. For the most part, it would be ludicrous and inappropriate to assume that proper informed consent could be obtained after such brief encounters.

My practise has now changed and is mostly to do with diagnostic and therapeutic anaesthesia. All patients are seen initially as a consultation during which treatment is planned. Full disclosure is made to the patient with respect to planned therapy, indications, contra-indications, and risk. Patients are thus informed and educated about anaesthesia. It is my opinion that for the patient who is contemplating surgery involving the administration of anaesthesia, after he/she has consulted with the surgeon, the next stop should be at the office of a consulting anaesthetist. This should be well in advance of the date of surgery. It is obvious that practising in this manner provides better patient care, decreases the likelihood of an uninformed and disgruntled patient, and raises the level of professionalism for the anaesthetist.

Edward J. Sheffman MD FRCPC DABA FACA

REFERENCE

1 Anaesthesia and medico-legal concerns. Can J Anaesth 1990; 37: 1–3.

Epidural air-filled bubbles and unblocked segments

To the Editor:

I read with interest the letter by Boezaart and Levendig[1] reporting an unblocked segment due to epidural air-filled bubbles demonstrated by peridurography. While this may serve to illustrate one of the problems of using loss of resistance to air instead of saline, it also illustrates a consequence of injecting an unnecessarily large volume of air. I estimate from the peridurogram that at least 5 ml had been injected. Was this necessary? Furthermore, I would question the suggestion that the catheter migrated into the subarachnoid space some distance from the site of entry into the epidural space as illustrated. It has been shown that migration of the catheter through the dura is very unlikely to occur, if at all, unless the dura has already been breached by the needle.[2] How was the "CSF" tested? The commonly used method in this situation is to test for glucose. It is not uncommon to be able to aspirate fluid from the epidural space some time after a top-up, and if tested, this fluid will be positive for glucose due to diffusion of glucose from the tissues of the epidural space into the top-up solution.[3] As further evidence in support of subarachnoid placement of the catheter, the authors cite the "unexpected behaviour of the block." I suggest that satisfactory analgesia after 8 ml of 0.25 per cent bupivacaine at the second lumbar interspace is entirely to be expected. Had the block lasted for three hours or more, or the spread been extensive, then subarachnoid placement may have been a possibility. Neither of these factors was mentioned. I submit that this was a completely normal epidural complicated only by an unblocked segment due to the use of an excessive amount of air.

Boyd H. Meiklejohn BSc MB ChB FFARCS
Dept. of Anaesthesia
Leicester Royal Infirmary
Leicester LE1 5WW, U.K.