

LETTERS TO THE EDITOR

DEAR SIR:

I would like to offer an historical note relating to the paper by Diamond¹ and associates which demonstrates rather convincingly (and with an enjoyable style!) that oral castor oil may act as a ligand for lipophilic sedatives, removing them from the circulation and shortening coma. In 1911 Graham² reported the ether-induced depression of bacterial phagocytosis and noted that olive oil *in vivo* (*per rectum*) or *in vitro* countered the effect. Presumably the olive oil also acted as a ligand but, unfortunately, there is no mention of the effect of the olive oil upon the rapidity of emergence from anesthesia!

FREDRICK K. ORKIN, M.D.,
Department of Anesthesia,
University of Pennsylvania,
Philadelphia, Pennsylvania

1. DIAMOND, M.J., BROWNSTONE, Y.S., ERCEG, G., KIERASZEWICZ, H., & KEERI-SZANTO, M. The reduction of coma time in lipophilic drug overdose using castor oil. *Can. Anaes. Soc. J.* 23: 170 (1976).
2. GRAHAM, E.A. The influence of ether and ether anesthesia on bacteriolysis, agglutination, and phagocytosis. *J. Infect. Dis.* 8: 147 (1911).

DEAR SIR:

In reply to Dr. Gordon Wyant's letter re "Awareness During Anaesthesia," I wish to commend him for his usual lucid and forceful way of expressing himself. He has elaborated on the main disadvantage of the relaxant-narcotic technique.

However, I wish to mention some of the advantages of this technique:

- (i) Economy,
- (ii) Reduction of pollution of O.R. by potent inhalational agents,
- (iii) Medico-legal. Our anaesthetists prefer not to expose a patient to halothane before at least 3 months after the first exposure,
- (iv) A challenge to the skill of the anaesthetist,
- (v) Constant vigilance of the patient is mandatory.

The patient should be monitored carefully for tachycardia, hypertension, sweating, tearing and pupillary dilatation, and a nerve stimulator used to avoid overdosing with the relaxant. Moreover, the technique should be abandoned for any particular patient whom it is difficult to keep adequately anaesthetized.

This technique will remain hard to master if teachers find it difficult to spend more time in the O.R. with their first year residents. The technique can be satisfying to both patient and anaesthetist and has a place in present-day anaesthetic practice.

B. PERSAUD, M.B., C.H.B.,
Anaesthetist

DEAR SIR:

In their paper, "Treatment of Low Back Pain with Acupuncture" Drs. Edelist, Gross and Langer (*Can. Anaes. Soc. J.*, 23: 303, 1976) have compared two groups of 15 patients each; one was treated with the insertion of needles into acupuncture points, the other with needling of non-acupuncture points. Both groups received identical electrical stimulation of the inserted needles. The results were evaluated after three treatments and there was improvement in 40 per cent in the "sham" acupuncture group and in 46 per cent of the real acupuncture group. In the opinion of the authors these results "fall into the realm of the placebo effect." On this basis they conclude that the results obtained did not appear to warrant further treatment, since there was no significant difference between the two groups and further that they were unable to differentiate any benefit of acupuncture for low back pain in excess of the placebo effect.

I don't think it is justifiable to make the general assumption that any treatment which produces results in the range of 40-50 per cent of the patients treated should be automatically regarded as placebo effect.

Moreover, I believe the authors are not justified in invoking the placebo effect on the basis of their findings. The "sham" acupuncture performed cannot be equated with a placebo. Wall¹ pointed out that "unless one takes the existence of the classical points at absolute face value, points away from the classical acupuncture points are not zero reference points; these are not tablets without pharmacological action. The other points too are generating a large afferent barrage." It should be noted, that the "sham" points used in this investigation were within the same segments of innervation as the acupuncture points and their electrical stimulation was certainly capable of inducing afferent impulses within the dermatomes involved in the process that caused the patient's pain and dysfunction. Indeed, it is conceivable that the electrical current, introduced into the tissue through the acupuncture needles, could stimulate a relatively large area including even the structures involved in the "true" acupuncture procedure.

In my opinion, the only conclusion that can be drawn from this study is that electrical stimulation, carried out three times in selected patients with low back and sciatic pain, produced improvements in nearly half the patients treated; there was no significant difference between the application of electrical stimulation to classical acupuncture points or to other points within the area of innervation involved in the pain inducing process.

The limited number of treatments and the lack of information on the actual response of those patients considered not improved leave the possibility open that more extensive treatment could have significantly influenced the results; in this regard I fail to understand the authors' conclusion, that the results obtained did not warrant further treatment.

W.E. SPOEREL, M.D., F.R.C.P.(C),
Professor and Chairman,
Department of Anaesthesia,
University of Western Ontario,
London, Canada

1. WALL, P.D. From "Advances in Neurology," vol. 4, International Symposium on Pain, (Editor: J.J. Bonica). Raven Press Publishers, New York, p. 833 (1974).