

bally to the patient, and stated clearly in the written consent form. It is only common sense that if the investigator has doubts about the patient's ability to comprehend, recruitment for study should not proceed.

My letter was intended not so much as to what information is required in an informed consent, but rather how the informed consent is obtained, especially from day-care surgery patients and in situations where there is a language barrier. In my case, the surgeon was a participating investigator who was in a good position to obtain informed consent. However, in other situations, attending surgeons, who are not participating investigators, may not be suitable for explaining the nature and risks involved. The move by many hospitals to preadmission clinics and same-day surgery creates a situation in which the investigator-anaesthetist may not be the one who sees the patient in the preadmission clinic. The non-investigator-anaesthetist who sees the patient in the preadmission clinic, and may not know all the details of the study, is not the appropriate person to obtain informed consent. Is it adequate for him/her to warn the patients regarding the study, as he/she may not be able to answer all the questions raised by the patient? Is it fair to the patient if the consent is obtained on arrival at the clinic, or minutes before surgery, even though the information includes the fact that refusal to participate would not jeopardize the quality of care? When informed consent is obtained through an interpreter, how can one be sure that none of the essential information is lost through the translation?

Clinical reports often simply state that "the study has been approved by the ethics committee and informed consent obtained from patients." However, it is the manner in which the informed consent is obtained in these situations that has not been addressed.

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PCA in burn injuries: the subcutaneous route

To the Editor:

Adequate pain control in burn injuries can be problematic due to wide variations in analgesic requirements.¹ In a retrospective study, 35 hospitalized patients suffering from acute burn injuries were assessed for three days after their injuries. A winged needle was inserted subcutaneously (sc) at a site distant from the burns. Morphine was given as an on-demand bolus dose of one milligram (mg) with a lockout time of six minutes. A background infusion of morphine ($1 \text{ mg} \cdot \text{hr}^{-1}$) was used routinely, but was discontinued if morphine requirements decreased below $20 \text{ mg} \cdot \text{day}^{-1}$.

Every four hours, the respiratory rate, sedation score, pulse rate, and blood pressure were recorded. Each day, an assessment was made of each patient, a database form was filled in, and any complications were noted. The % body surface area burnt was recorded. Pain was as-

sessed daily by the patient using a ten-point visual analogue pain scale. The quality of analgesia was also indirectly assessed by determining the ratio of successful to unsuccessful demands, the proviso being the higher the ratio the better the analgesia (or the less anxious the patient).^{2,3}

Vomiting was seen in only one patient. No oversedation or respiratory depression occurred. Localized swelling and induration at the sc infusion site was found in two patients. The sc site was easily resited. A positive relationship between pain scores and body surface area burnt has previously been reported.⁴ No such relationship occurred in this study.

However, sc PCA (with morphine) was found to be a safe and effective way of controlling burn pain. There is often a paucity of readily accessible veins in patients with burn injuries. The sc route has the advantage of reducing time taken to maintain a dedicated intravenous line, and is easy to initiate and maintain. To the best of our knowledge, it is the first time that the sc route has been used in this way.

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Hyperkalaemia after warm heart surgery

To the Editor:

We read with interest the case report of severe hyperkalaemia following warm heart surgery.¹ In our experience of over 900 cases of warm heart surgery we have