LETTERS TO THE EDITOR

Electroconvulsive therapy

Sir:

I have read with great interest the very comprehensive and thoughtful paper of "Anaesthesia for Electroconvulsive Therapy" by Rich and Smith in the March, 1981 issue of this journal. Having been interested and active in this field for a number of years, I may be permitted to make an observation on the subject of preliminary atropinization for this particular procedure. Dobkin investigated this subject in 1959[1,2] and came to the conclusion on the basis of animal work that the preliminary administration of relatively large doses of atropine was an essential precaution. We have had occasion to investigate this subject again in man under controlled conditions and have found that atropine contributes nothing to patient safety.[3] It is quite true that a brief period of bradycardia is occasionally seen when atropine has not been given, but this rarely exceeds 60 beats per minute and is almost invariably followed by a period of considerable tachycardia due to the post-shock release of catecholamines. This tachycardia could conceivably be enhanced by belladonna pretreatment. There is also the question of cardiac sphincter relaxation by atropine, an undesirable condition in the presence of convulsive movements which might cause regurgitation of liquid stomach contents. We were surprised during our studies that salivation was no great problem and the incidence of this was no greater without than with atropine. Consequently we have come to the conclusion that atropine is at best an unnecessary adjunct and might even contribute to morbidity. We have not used atropine now since the conclusion of our study two years ago and have had no reason to regret this decision.

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3. Wyant, G.M. & MacDonald, W.B. The Role of Atropine in Electro-convulsive Therapy. Anaesth. Int. Care, *8*(4): 445–450 (1980).

Blood Cross-Match for Caesarean Section

Dear Sir,

I am writing to comment on a paper in the Canadian Anaesthetists' Society Journal in March 1981 by E.W. Hew, S.H. Rolbin, A.F.D. Cole, and S. Virgint: "Obstetrical Anaesthesia Practice In The University of Toronto Hospitals and Some Randomly Selected Community Hospitals" (Vol. 28, pp. 158–166).

I found the results of the survey interesting and worth reading. However, I have reservations regarding the authors comments which do not allow discussion of differing views.

For example, on page 162, the authors comment that "... all patients due to have a Caesarian section should be crossmatched for two units of blood, which are then kept in the delivery room." Our practice has been to take blood for typing and screening only. The blood sample is then held in the blood bank. Crossmatching is done when blood is actually required. With this type and screen system, type-specific blood can be available immediately and fully crossmatched blood in about 30 minutes.

I studied the hospital records at St. Joseph's General Hospital in North Bay to review our transfusion experience. From December 1978 to December 1980 there were 430 Caesarian sections done by four surgeons. Only 16 of these patients (3.7 per cent) received a blood transfusion at any time during their hospital stay. The accompanying table displays the timing of and reasons for blood transfusions.

None of the patients receiving blood transfusions postoperatively had unusual blood loss during operation or hypotension or tachycardia in the recovery room. All the patients who were anaemic or had bleeding preoperatively had crosssmatches done immediately. The only two patients for whom blood in the operating (or delivery) room could possibly have improved their management were those with uterine tears