



FIGURE Répartition des longueurs estimées de l'aiguille de péridurale.

même que face à l'anesthésie en général. Deux parturientes seulement ont refusé de voir l'aiguille, ce qui montre le désir d'information de ces femmes. L'anxiété diminuait après la présentation de l'aiguille, l'EVA allant de 39 ± 26 à 33 ± 24 $P < 0,001$). De plus, cette diminution d'EVA était > 20 chez 20 % des parturientes et 30 % des craintives. Seulement quatre parturientes (1,6 %) ont eu un EVA augmenté de plus de 20, toutes multipares, n'exprimant pas de crainte et surestimant très peu la longueur de l'aiguille (< 15 cm). Bien entendu ce nombre n'est pas suffisant pour en tirer des conclusions définitives. La longueur de l'aiguille était surévaluée dans 80 % des cas (Figure), mais la longueur estimée moyenne de l'aiguille était la même dans les deux groupes (13 ± 6 cm). La longueur estimée, même largement surévaluée n'est donc pas forcément source de crainte face à la péridurale.

En conclusion, il faut donc montrer l'aiguille de péridurale aux parturientes pour les rassurer, mais pas aux multipares confiantes qui surestiment peu la longueur de l'aiguille. Cette constatation devra être vérifiée par une plus grande série.

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Références

- 1 Matthey PW, Finegan BA, Finucane BT. The public's fears about and perceptions of regional anesthesia. *Reg Anesth Pain Med* 2004; 29: 96–101.
- 2 Millar K, Jelicic M, Bonke B, Asbury AJ. Assessment of preoperative anxiety: comparison of measures in patients awaiting surgery for breast cancer. *Br J Anaesth* 1995; 74: 180–3
- 3 Kelly AM. The minimum clinically significant difference in visual analogue scale pain score does not differ with severity of pain. *Emerg Med J* 2001; 18: 205–7.
- 4 Todd KH. Clinical versus statistical significance in the assessment of pain relief. *Ann Emerg Med* 1996; 27: 439–41.
- 5 Kindler CH, Harms C, Amsler F, Ihde-Scholl T, Scheidegger D. The visual analog scale allows effective measurement of preoperative anxiety and detection of patients' anesthetic concerns. *Anesth Analg* 2000; 90: 706–12.

New information on the first anesthetic in Canada

To the Editor:

The first ether (and first) anesthetic in Canada was performed January 18th 1847 by an American dentist in Saint John, New Brunswick.¹ Dr. E. Dagge Worthington was the first Canadian to perform an anesthetic in Eaton Corner, Quebec, March 11th 1847 (Figure). He published his case in the *British American Journal of Medical and Physical Sciences*^A and also reported the case in his autobiography.² He described a leg amputation with the patient awake under ether sedation:

“Stone, during the whole time of the operation, retained his consciounness, talked rationally, and made some witty replies to questions put to him, converting the scene from one of a painful to a most ludicrous character.”

Among the witnesses cited to the procedure is Reverend Mr. Sherrill. We recently came across Reverend Sherill's diary. There are three references to W. Stone in the diary, corresponding to the below-knee amputation (March 11th 1847), and surrounding the femoral artery ligation (March 14th 1847) and above-knee amputation (April 3rd 1847).

In the margins of the diary dated Thursday March 11th he wrote:

A Worthington ED. Case of amputation of leg: the patient under the influence of sulphuric ether vapour. *Br Am J Phys Sc* 1847; 3: 10.



FIGURE Public notice in the village of Eaton Corner, Québec. Situated in front of the lot where Dr. Worthington performed an amputation March 11th 1847.

“Dr. Wirthinton cut off Mr. W Stone’s leg below his knee. Done with the influence of Sulphuric ether gas-he was not conscious(...). 7 or 8 were present”

In the margins of the diary dated Sunday March 14th, Reverend Sherrill wrote:

“The artery in Mr. Stone’s leg broke and the Doct. took it up above the knee.”

Finally, in the main text dated Saturday April 3rd, Reverend Sherrill wrote:

“Stopped to see Mr. W Stone. The artery burst again. It was bound above by a ‘turnaket’ but he was in agonizing pain. I never witnessed anything like it before. Hope I never may again. He seemed ...atty resigned. “The suffering’ he said ‘was terrible. But God knew first’.”

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References

- 1 Shephard DA, Turner KE. Preserving the Heritage of Canadian Anesthesiology. A panorama of people, ideas,

techniques and events. Canadian Anesthesiologists’ Society Meeting 2004: 1–2.

- 2 Worthington ED. Reminiscences of student life and practice. Sherbrooke 1897: 81–2.