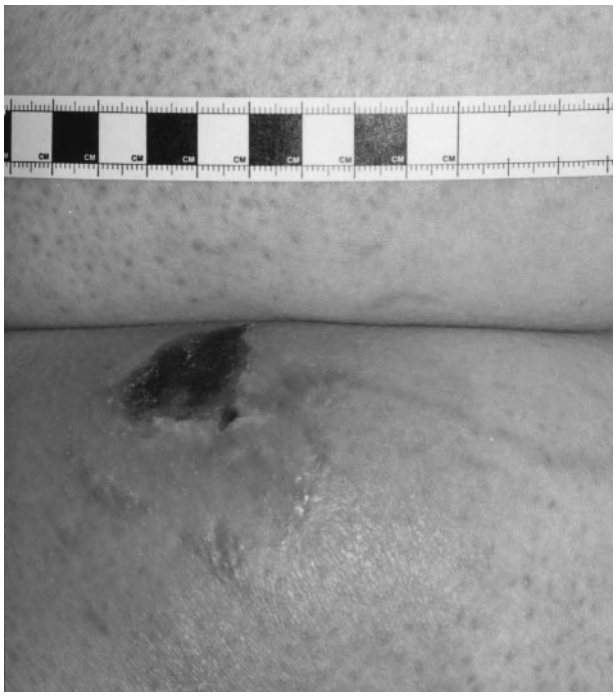

Fig. 1 Pressure sore on right buttock.

following a long labour at term. An epidural catheter had been in situ for over 9 h, during which time she was totally immobile. The epidural insertion had been uncomplicated and she received three 10-mL bolus doses of 0.25% bupivacaine with good effect. On the first postnatal day a pressure sore was noted on the right buttock (Fig. 1). With conservative treatment it healed rapidly and had completely resolved within 6 weeks. The immobility of this patient and lack of sensation clearly contributed to the development of the pressure sore. This case illustrates the need for awareness of this potential problem, which may be avoided by simple preventive measures.

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doi: 10.1054/ijoa.2000.0817

Anaesthesia for caesarean section in a parturient with Friedreich's ataxia

We report the case of a 27-year-old primigravida with a history of Friedreich's ataxia, scheduled for elective caesarean section. Caesarean section was the chosen mode of delivery due to breech presentation and increasing muscle weakness. She had become wheelchair-dependent at age 19, suffered from moderate to severe dysarthria and had a slight lumbar scoliosis. Electrocardiogram, echocardiogram and clinical assessment of respiratory function were normal.

Spinal anaesthesia was performed in the sitting position, at the L2–3 interspace, with a 25-gauge Whitacre needle. A 2.5-mL dose of 0.5% hyperbaric bupivacaine with fentanyl 25 μg was administered. A satisfactory block to T4 was obtained. Hypotension or other cardiovascular changes were not observed. The postoperative period was uneventful. Follow-up visits several months later did not reveal any changes in her neurological condition.

Friedreich's ataxia is the most common of the hereditary ataxias.[1] It is caused by degenerative lesions, which are localised chiefly to the dorsal half of the spinal cord and cerebellum. Weakness of respiratory muscles and myocardial involvement resulting in hypertrophic cardiomyopathy are common features and are the most frequent causes of death, usually in the third decade.

Patients with Friedreich's ataxia have demonstrated both hypersensitivity[2] and normal responses[3] to non-depolarising muscle relaxants. Other anaesthetic concerns are the high incidence of cardiomyopathy and poor lung function due to scoliosis.

We chose a spinal technique as the preferred method for surgical anaesthesia as it avoided the concerns associated with general anaesthesia. Also in comparison with a lumbar epidural technique, there was a reduced risk of a patchy block due to scoliosis. This, to our knowledge, is only the second reported case of spinal anaesthesia for caesarean section in a patient with Friedreich's ataxia.[4]

We would like to hear of other people's experiences, or comments, regarding the use of spinal anaesthesia in parturients with Friedreich's ataxia.

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doi: 10.1054/ijoa.2000.0771

Elective caesarean section on request

There is increased emphasis on patient choice in obstetric practice in the UK.[1] Debate continues over whether elective caesarean section on request is justified.[2,3] A structured anonymous postal survey revealed that 17% of obstetricians would prefer elective caesarean section if they or their partners were pregnant for the first time in an otherwise uncomplicated pregnancy.[4] Female obstetricians were significantly more likely to prefer caesarean section than their male colleagues (31% vs. 8%). A recent survey of female midwives, however, showed only 4% would request caesarean section in similar circumstances.[5] Suggested reasons for this difference included the greater exposure of midwives both to normal deliveries and to the relative difficulty a mother has nursing her baby after caesarean section.

We wished to investigate the preferences of anaesthetists – another group of health care professionals intimately involved with obstetric patients. We conducted a structured anonymous postal survey of 90 anaesthetists within the East Anglia region – 50 specialist registrars and 40 consultant obstetric anaesthetists. Seventy-six questionnaires were returned (response rate 84%). Of these, 14% of anaesthetists would prefer elective caesarean section in the absence of any obstetric indication. Females appeared less likely than males to prefer elective caesarean section (8% vs. 15%), although this difference was not statistically significant. The reasons cited for preferring caesarean section were possible perineal damage during delivery (100%), long-term sequelae (100%), safe delivery of the fetus (82%), future sexual dysfunction (73%) and electively-timed delivery (45%). These results suggest that a similar proportion of anaesthetists and obstetricians are convinced of the merits of operative delivery.

We also found that 33% of anaesthetists thought caesarean section on request should be available in the National Health Service (NHS), whilst 59% thought it should be available in the private sector. A third of anaesthetists felt caesarean section on request should be available in the NHS but over half were willing to accept the principle if funded privately. This implies that part, but by no means all of the objection to caesarean section on request is one of limited resources. It would appear that the majority of anaesthetists agree that caesarean section on request is not justified in an already overburdened NHS.

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doi: 10.1054/ijoa.2000.0849

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doi: 10.1054/ijoa.2000.0846

Management of headache due to multiple dural punctures

The report by Adejumo[1] was interesting. However, we would like to raise several points regarding the management. The first question is: how many dural punctures with a Tuohy needle can one afford to do before thinking of alternatives? Since the anaesthetist