marginal effect. As for the validity of comparing percentages, the conclusions are reasonable in the context of unequal total numbers between the groups. The main aim of our study was to raise the profile of school safety and trigger further studies by the A&E practitioners on this very important national and international issue. We are pleased with the response, even if it is critical.

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Topical analgesia for children

EDITOR,—We read with interest the paper of Kendal et al. and wish to raise a few questions. The authors described in detail how the adrenaline-cocaine gel was applied to the wounds but, apart from stating that the lignocaine injections were “standardised using a 25 gauge needle”, we know nothing about the technique used, who injected and suctioned (nurse, SHO, registrar, etc.), nor the time given for the gel to act before starting the suturing. Standardising the needle gauge and suture size for all lacerations regardless of the site to simplify analysis and satisfy statisticians is not surgical practice because it means using heavy thread for the face or fine thread for the trunk. Also, to alleviate fear of the “sight of the needle”, a point made by the authors, is obviously desirable, but how did they alleviate fear of the sight of the stitching needle, the forceps, and the needle-holder? To find out that 40% of patients and/or parents considered suturing lacerations under lignocaine “unacceptable” may simply mean poor overall technique. How do they account for this extraordinarily high patient/parent dissatisfaction? We also want to know the authors’ explanation of their high “failed” anaesthesia rate of 24% in the lignocaine group and how they managed this subgroup: did they proceed regardless or was more lignocaine given, or was the gel therefore applied?

Another unclear point is the authors’ evaluation of cost. They state that the gel costs £2 per application, while a 10 ml ampoule of lignocaine costs 25p. Although they were only dealing with lacerations less than 2 cm in length, that was based on the belief that even after considering patient volume, the overall cost implications were tiny. How can they explain this, given that a 1.9 cm cut should only require a 5 ml ampoule priced at a mere 16p? Also why haven’t they tested any of the available lignocaine gels? Although they are not licenced for open wounds, neither is the adrenaline-cocaine gel, and lignocaine gels are available in all accident departments.

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Fasting before Bier’s block

EDITOR,—We wish to respond to the article by O’Sullivan et al relating to the need for patient fasting before manipulation of a fracture under Bier’s block.1 Having recorded a low incidence of complications by postal questionnaire, the authors concluded that fasting was unnecessary and suggested that instead of conferring additional safety, anaesthesia served to delay treatment. We feel this study is seriously flawed, and that to alter clinical practice as a consequence must be regarded with caution. The suggestion that this hypothesis be adequately tested it would be necessary to conduct a prospective study; it is likely that to attain the necessary level of power, a large number of patients would need to be studied.

To conduct a Bier’s block safely it is necessary to produce strict written guidelines defining technique, equipment, level of monitoring, assistance, and necessary level of clinical experience of the practitioner. Complications are far more likely when these conditions are not met. The questionnaire in collecting information failed to ascertain adequately how the responding departments audited these data or whether each department had issued guidelines. Several points arising from the data inferred that current practice was neither entirely safe nor effective: (1) the three units still used lignocaine; (2) the large number of respondents reporting the use of additional sedation/analgesia; (3) the significant number of reports of equipment failure.

The article tends to trivialise the potential risks of the Bier’s block, as well as using incomplete data to propose a serious change in clinical practice. To omit a fasting period merely as an exercise in cost saving is frightening time would be foolhardy. In the context of risk management, any litigation arising from this questionable change in practice could be financially damaging to any Trust. It would be interesting whether in the light of adequate explanation of potential risk, the patient would view the fasting period as nothing more than minor inconvenience.

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EDITOR,—We read with interest the article by O’Sullivan et al questioning the need for starvation before prilocaine Bier’s block. While we agree that the retrospective audit appears to show no morbidity directly attributable to a full stomach, we would question the conclusion that fasting is unnecessary.

Traditional teaching for anaesthetists is to prepare patients for Bier’s block with the same attention to detail given to those undergoing general anaesthesia. This includes fasting to reduce the risk of aspiration, as the airways’ protective reflexes may still be compromised in the awake patient if, for example, hypoten- sion or fitting occur. Both of these complications can be precipitated by local anaesthetic toxicity. As 23 (of 122) centres reported equipment failures—of which 18 mentioned stuff leak—we can see that this scenario is far from implausible.

Of greater concern is the concurrent use of sedation in 21 centres. This practice, which on its own can compromise airway reflexes, is in our opinion an absolute contraindication to a non-fasting policy. Furthermore, in the paper’s concluding comments, this potential danger was not addressed at all.

The apparently low incidence of morbidity in this report, and the fact that there have never been any deaths related to the use of prilocaine Bier’s blocks, does not preclude the need for fast patients. The continuation of stomach contents remains a real threat which can have catastrophic consequences;