intracranial mass if the patient’s mental status deteriorates after CSE.

B. Guner
E. A. Kose*
S. B. Akinci
N. Celebi
B. Celebioglu
U. Aypar
Ankara, Turkey
*E-mail: arzuhct@hotmail.com

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Entrapped central venous catheter

Editor—The case presented by Dhanani and colleagues1 formed an interesting and informative read. I commend the authors on the careful way in which they handled the situation. However, a couple of points struck me:

(i) The main reason for putting in a new catheter was the suspicion that the old one could have been infected. So if the new catheter had passed through the old (‘supposedly infected’) catheter, was it wise to leave the new one in situ? Surely this defeats the very purpose for which the whole exercise was started?

(ii) In the management algorithm, the method of continuous gentle traction seems like one that could go either way, in that this could also gradually increase the tear and end up with what you wanted to avoid in the first place—a complete fracture?

V. Paul
York, UK
E-mail: drvarghesepaul@yahoo.com

Editor—We thank Dr Paul for the concerns raised and the Editor for the opportunity to respond. In reply, there is concern regarding the new catheter becoming contaminated by the old. Though there are different ways for line-related infection to develop (contaminated hub, insertion site infection, bloodstream infection, etc.), we cannot find any evidence for catheter entrapment increasing the risk of infection. We do not believe our approach posed any greater risk than the common practice of inserting a new line prior to removal of the older one even when they may brush against each other in vivo. Furthermore, after one major procedural complication, we felt it prudent to leave the new line in situ and consider a line change only if there were ongoing concerns of catheter-related sepsis. Fortunately, the patient improved clinically and was discharged without further complications.

With regard to the management algorithm, the approach was formulated after considering the extent of the fracture, the degree of entrapment, and the available institutional resources. There were also concerns regarding the volume of contrast media needed as more would be required if catheter manoeuvring was attempted. We believe gentle traction would be appropriate as a first line intervention in cases with minimal entrapment (<25% of circumference) and fracture.

J. Dhanani
S. Senthuran
R. Olivotto
R. J. Boots
J. Lipman*
Brisbane, Australia
*E-mail: j.lipman@uq.edu.au

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Bedside prediction of central venous catheter insertion depth

Editor—I read this article1 with keen interest, as it may change the practice of routine chest X-ray (CXR) after central line insertion in ICU patients. This practice can lead to a decrease in cost of patient care and radiation exposure. However, this technique of checking line tip position is not suitable for those patients who have no CXR before central line insertion. If a patient requires a CXR to establish the position of the carina and to measure length from the clavicle notch to the carina, then why not do this after central line insertion, when we can see the tip of the line and serious complications such as pneumothorax. Another point is that the length between the
insertion site, clavicular notch, and carina is a subjective measure which may lead to bias and erroneous results.

M. Farooq  
Dublin, Ireland  
E-mail: muhammadfarooqch@yahoo.com

Editor—We would like to thank Dr Farooq for his interest on our article. However, there seems to be some misunderstanding. The practical purpose of our study was not to prove that a CXR may be omitted after central venous catheterization, but to minimize post-procedural adjustments of central venous catheter insertion depth. We agree that our technique is not so helpful for patients without prior CXR. Patients likely to require central venous catheterization may well have a CXR taken before operation or before being admitted to ICU. Although it was not studied, it is probable that optimal central venous catheter insertion depth should depend on the distance from the insertion point to the clavicular notch. Moreover, it is possible that very tall patients would have the clavicular notch appear more peripherally on the CXR, augmenting the clavicular notch to carina distance as the parallax effect would be greater peripherally. However, because routine posterior–anterior CXR is taken at a fixed distance between the X-ray tube and film (72 in), we think that such bias is negligible in most cases. If we measure the insertion point to clavicular notch distance after insertion of a guidewire or catheter, there is no reason to introduce any serious error during simple distance measurements.

J.-H. Bahk*  
J.-T. Kim  
Seoul, Korea  
*E-mail: bahkjh@snu.ac.kr

Postoperative management of patients with obstructive sleep apnoea syndrome

Editor—Patients with sleep apnoea are particularly at risk from the respiratory depressant effects of inhaled anaesthetics, sedatives, and opioids after operation. Reduced upper airways tone during deeper rapid eye movement (REM) sleep and stage 3 and 4 non-REM sleep may make hypoxic damage more likely. Continuous positive airways pressure (CPAP), a means of preventing airway collapse, is the definitive treatment for sleep apnoea. Some patients have their own machines at home and the American Society of Anesthesiologists recommends that either CPAP or non-invasive positive pressure ventilation should be administered after operation to patients using these modalities before their operation.

We have explored the use of protocols to manage these patients. A questionnaire survey was sent to 199 Consultant anaesthetists based in 102 hospitals in the UK. The respondents were asked if their anaesthetic department had a protocol for the management of sleep apnoea patients after operation and related questions about the use and availability of CPAP.

Seventy-two replies were received, giving a response rate of 36%. Only 4% of respondents stated that their hospital had a protocol for the postoperative management of sleep apnoea patients. The absence of such protocols creates the potential for great variability in how these patients are managed and possibly poorer outcomes for some patients. It raises questions about what criteria anaesthetists are using to guide patient management.

The majority (85%) of respondents said that they would ask patients to bring their own CPAP machines to hospital, but 46% advocated the provision of hospital-owned CPAP machines to patients. However, 23% disagreed with this policy. Only 17% of respondents thought that their hospitals would always be able to provide sleep apnoea patients with CPAP machines.

Few UK hospitals appear to have protocols for the management of sleep apnoea patients after operation. There appears to be a lack of consensus in the practices adopted by anaesthetists when managing these patients. We recommend the implementation of evidence-based guidelines at a national level, which should in turn generate the development of protocols locally.

C. Obuaya*  
V. Punciaheva  
M. Farooq  
Basildon, UK  
*E-mail: c_ohuaya@hotmail.com

2 Anon. Practice guidelines for the perioperative management of patients with obstructive sleep apnea—a report by the American Society of Anesthesiologists Task Force on the perioperative management of patients with obstructive sleep apnea. Anesthesiology 2006; 104: 1081–93  

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