Correspondence

Cardiac Arrest and Bone Cement

SIR.—In the first six months of this year we have seen four deaths following the use of the Thompson prosthesis in patients with fractured femurs. One of these collapsed and died on the operating table. All showed evidence of severe fat embolism after histological examination of the lungs, brain and kidneys. We shall report them in more detail later.

Dr. J. N. Powell and colleagues (8 August, p. 326) did not exclude fat embolism as a cause of death in their cases. None of our cases had cutaneous petechiae at necropsy, so that this sign is not always a reliable indication of fat embolism. Dr. J. N. Powell and others did not comment on petechiae in their patients.—We are, etc.,

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Workload of Anaesthetists

SIR.—We write to answer Dr. J. C. Ainley-Walker’s question (18 July, p. 161).

We took as our definition of the duration of an operation list the time from the induction of anaesthesia in the first case to the time the last case left the operating theatre. This is not intended to imply that we think that this is or should be the limit of the anaesthetist’s involvement with his patient. We used this because it is the incontrovertible minimum requirement of anaesthetic time. The difficulty with the other definitions is that the beginning and end of the occupancy of an anaesthetist with his patients are definable in so many ways that there is almost no limit to the amount of work that one could allocate to this task.

The purpose of our paper (4 July, p. 39) was to make clear the type of staffing structure implied by the Godber Report1 in view of the present sessional obligations of the two departments in which we work. The points at issue are: first, how many anaesthetists are to be covered, and, second, are these sessions fully used? Because of such factors as Dr. Ainley-Walker mentions we suggest that if the average session has a minimum requirement of the order of three hours it is very unlikely that any reorganization of the work could lead to significant reduction in the number of sessions to be covered. This is the sole value of quantifying them in this context.

It must be obvious to practising anaesthetists that lists vary greatly from one week to another. We have expressed our own experience of this in the large standard deviation of list length compared with the mean length. In the day-to-day organization some of this variation can be allowed for, since it is in part predictable once the list is published. For the broader considerations we wished to discuss the relevant factor is the number of sessions that must be staffed. This sessional obligation, we suggest, must be taken as the present number of sessions covered, unless there is evidence of under-use. There are many ways of examining this, but we think the definition we have used suffices for the purpose, and does not depend on factors

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REFERENCES