

Anaesthetist required for Uganda

I write from the Milago Hospital, Kampala, Uganda, where I am employed as a general surgeon. We are having difficulty in staffing the anaesthetic department. The last physician-anaesthetist (Dr Kityo) has recently retired and there are now no medically qualified anaesthetists in the hospital.

A few Ugandans have specialised in anaesthetics after qualifying in medicine, but they have either not finished their training or have left the country. Formerly medical assistants were given a further 18 months training in anaesthetics to become 'medical assistant anaesthetists'. This scheme was given up some years ago and there are only a few medical assistant anaesthetists still around.

A few years ago it was decided to take suitable candidates with 'O' levels straight from school. These had a 3 year training in anaesthetics, the first year being theory, the second year mixed theory and practice and the third year entirely practical. The products of this training are designated as 'anaesthetic assistants'. They can be of reasonable quality but the scheme is likely to collapse unless an experienced medical anaesthetist is found to run it.

I have spoken to the Ugandan Minister of Health

(Professor Sebuwufa—an anatomist) and he would welcome anaesthetists in the service of his Ministry. I spoke to the Aid Representative with the British High Commission here and there is a possibility of the British Government supplementing an anaesthetist under the Overseas Service Aid Scheme or Inter-University Council Scheme.

Housing is in very short supply at the moment and is a major problem. Shortages and transport difficulties are likely to make the supply of some anaesthetic agents such as fluothane trichloroethylene and nitrous oxide erratic for some time and the anaesthetic assistants will probably have to rely on ether and the EMO for the bulk of their work.

I would be very pleased to hear from anyone who might be willing to respond to this challenge.

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An aid to identification of the subarachnoid space with a twenty-five gauge needle

The possibility of a low pressure headache, resulting from cerebrospinal fluid (CSF) leakage through a dural puncture, limits the choice of subarachnoid block as a local analgesic technique, especially during labour and in the younger surgical patient. The incidence of headache can be minimised by the use of a small-bore needle¹ and by avoiding multiple dural puncture. The novice finds it difficult both to control the direction of insertion of a 25 or 26 gauge (G) needle, and to identify the subarachnoid space. Most junior anaesthetic staff are, however, experienced in identifying the epidural space with a larger bore needle. We have developed a technique which will reliably identify the subarachnoid space with a 25 G needle. A 20 G \times 7.5 cm spinal needle (Needle Industries Ltd) is advanced into the epidural space, using loss of resistance to injection of air or saline as the end-point. This needle then serves as the introducer for a 25 G or 26 \times 10.0 cm spinal needle (Needle Industries Ltd) which can be protruded up to 1.2 cm beyond the point of the 20 G needle.

As the finer needle is advanced to puncture the dura there is a distinct 'click', and the position is confirmed by removal of the stylette and gentle aspiration of CSF with a 1 or 2 ml syringe. The local analgesic is then injected, and the needles removed together. Accidental dural puncture with the 20 G spinal needle does not appear to occur more frequently than when epidural block is being attempted with a 16 or 18 G Tuohy needle.

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Reference

1. ENG M. Spinal anaesthesia for vaginal delivery clinics. *Obstetrics and Gynecology* 1975; 3:579-90.

Low dose ketamine and diazepam during spinal analgesia

In their paper (*Anaesthesia* 1978;33:10) Dr McLaren and his associates described their method of spinal analgesia, which is essentially the same as used for elderly patients undergoing surgical pro-

cedures in Cardiff to correct fractures of the neck of the femur, with the exception of the technique of providing analgesia and sedation during the procedure. Dr McLaren's patients were sedated with an