or ADP alone (Type-III). The aggregation studies required for diagnosis of sticky platelet syndrome was not done in this study as facilities of an aggregometer was not available then. The same has now been installed in the centre and is being included in future studies on thrombophilia cases.

- (d) The association of oral contraceptives with thrombophilia is a well known fact. In this study, out of 42 patients, 19 patients were female in the age group of 02 years to 73 years. Of these, five patients were on oral contraceptives for durations varying from 6 months to 2 yrs, of whom only one patient had APCR.
- (e) Malignancy is an important cause of thrombophilia which has been emphasised in this article and elsewhere also in studies from our centre [3].

Systemic Sclerosis with Early Pregnancy

Dear Editor,

This is with reference to the case report titled 'Anaesthetic Management of a case of Early Pregnancy with Systemic Sclerosis' (MJAFI 2005; 61: 287-8). The authors are complimented for the successful management of medical termination of early pregnancy in an old case of Systemic Sclerosis. However, the readers will benefit if few points could be clarified further.

1. It is mentioned in the article that the measurement of arterial pressure can be difficult and misleading especially with a reduced forearm blood flow. However, in the case report, the readers do not get to know how the arterial pressure was monitored, what the site was and whether it correlated clinically. The readers would benefit by knowing various possible methods of measurement of blood pressure and also, oxygen saturation, without which the basic monitoring in such a high risk case would be incomplete.
2. This patient appears to be a case of difficult airway with features of restricted temporomandibular joint mobility, Mallampatti III and 3cms inter-incisor distance. It is mandatory that when such a case is administered general anaesthesia (GA), a difficult airway cart be ready with various airway adjuncts like various sized endotracheal tubes, laryngeal mask airway,

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combitube or fiberoptic bronchoscope, notwithstanding the expected duration of surgery.

3. Regional techniques are acceptable for peripheral surgeries in patients with Raynaud's phenomenon [1]. In this case, a paracervical, caudal or a low subarachnoid blockade could have been considered using limited doses of local anaesthetic. The patient can be counselled properly, explaining the risks of GA. Distortion of regional anatomy may cause difficulty in spinal procedures but a paramedian approach in sitting position, usually gives successful outcome.
4. It would have been a greater concern for the anaesthesiologist had the patient reported for a Caesarean section or any other major surgery. The discussion of the same would have been quite interesting.

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REPLY

Dear Editor,

We wish to thank the respondent for the interest shown in the article.

1. Measurement of arterial pressure is a challenge, specially if the duration of surgery is long and it involves blood loss. Vasoconstriction tends to make measurement of blood pressure by auscultation unreliable, necessitating the use of an ultrasonic blood pressure sensor [1]. We used a standard adult Non Invasive Blood Pressure cuff on the right arm to measure BP during the procedure. It was reliable in our case and correlated well clinically. The thighs or legs can be used as alternate sites for blood pressure measurement keeping in mind the size of the cuff and adequacy of circulation. As discussed invasive BP monitoring should be avoided specially in the presence of Raynaud's phenomenon. Preventing the occurrence of Raynaud's phenomenon has been discussed in the article. Keeping the patient warm is of utmost importance in this

situation. Despite measures taken by us, measurement of oxygen saturation was not possible. Depending on the type of surgery and likely duration, invasive monitoring by performing arterial blood gas analysis may be considered. The location and site of arterial puncture require careful selection.

2. Our patient had a difficult airway and we anticipated it. Mask ventilation however seemed possible. A difficult airway cart as suggested was kept ready and available. It did not have combitubes or a fiberoptic laryngoscope, as they were not available in our hospital at the time of performing this procedure. We were prepared to perform an emergency tracheostomy if the situation so demanded.
3. Regional techniques are more acceptable and were offered to the patient. There was no distortion of regional anatomy in our patient (for which a spinal by paramedian approach could have been performed). Despite comprehensive counselling our patient agreed only for a general anaesthesia.

- Should the same patient have had to undergo a major surgery it certainly would have been more challenging. Our article gives general guidelines to the anaesthetic approach of a patient with systemic sclerosis and also a discussion relevant to our patient. Though of significant importance, it was not feasible to describe in great detail the various other possibilities and clinical scenario that could have otherwise arisen.

Administration of Mantoux Test in ARMED FORCES MEDICAL SERVICES - Need for Change

Dear Editor,

- In most of the hospitals in armed forces at present, mantoux test is being carried out by the personnel of Station Health Organisation. Since these personnel are also responsible for administering BCG/other immunisation, this test is often combined with the rest of the immunisation. Since the immunisation in most of the centres is conducted once a week, mantoux test is also carried out weekly. For the patient, in practice, this means multiple visits to the hospital leading to avoidable inconvenience, wastage of precious man hours and delay in diagnosis. This practice therefore needs to be changed.
- Mantoux test is a clinical investigation and like any other investigation, should be carried out daily. Also, since all what this entails is a intra-dermal injection, there is no reason to restrict its administration by personnel of SHO/Health section.
- Following measures are suggested to make the administration of this important diagnostic test more patient and doctor friendly-
 - For indoor patients, the medical officer of the respective ward should indent PPD from the medical store of the hospital and administer the test as and when required and not at any fixed time or day. He should himself take the reading after the prescribed time, in order to reduce inter-observer variation.
 - For out patient department (OPD) patients it can be indented

Reference

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and stored in the refrigerator of the medical inspection room. Administration could be done daily during OPD hours by any trained para medical staff manning the injection room of the medical inspection room. The reading of the test can be taken by the medical officer/specialist officer ordering the test while reviewing the patient with the investigation reports. The result of the test should be read as per the guidelines of Revised National Programme of Tuberculosis [1].

- The above model, successfully implemented at Base Hospital, Delhi Cantt for about 3 years, has been greatly appreciated by both the patients and the treating physicians. Reduction in the load of patients on the immunisation clinic with out increasing the manpower requirement on the already strained staff position is an added advantage.

Reference

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Book Review

Practical Obstetric Haematology. Edited by Peter Clark and Ian A Greer. Published by Taylor & Francis, 2000 NW Corporate Blvd BOCA, Raton, FL 33431, USA. Hard bound 196 pages; Price £ 44.99; ISBN 1-8424-262-3.

In the last 10 years there has been a rapid expansion in the clinical interaction between hematologists and obstetricians. As a result there is an increasing challenge to hematologists, obstetricians and midwifery staff to understand and manage the clinical manifestations of a number of rapidly developing areas of hemato-obstetric science.

This book is intended to serve practitioners involved in haematology, obstetrics and vascular medicine. The book is designed to assist the reader in diagnosis and treatment of these conditions and provides a user-friendly, but authoritative, source of information on the pathophysiology of hemato-obstetric problems that

incorporates the best practice contained within internationally accepted guidelines of obstetric and haematological care.

The book is intended to assist the reader in rapidly assimilating the essential aspects of the pathophysiology of these conditions as well as guide to the pitfalls associated with investigation and treatment. Each chapter has similar format and employs extensive use of tables and figures.

To assist the reader, each of the chapters in the book conforms to a similar style that includes: pathophysiology; presentation; differential diagnosis; diagnostic tests; diagnostic difficulties; maternal complications, foetal complications; and potential management complications. Each chapter also includes tables summarising the key points in diagnosis and management, as well as information on the likely impact of new therapies and a preview of the developing issues relating to each condition.