MEHTAS LIGATURE FORCEPS FOR TONSILLECTOMY

Dear Editor,

There are many methods for achieving primary haemostasis in the tonsillar fossa after tonsillectomy. A common method is that of ligating the bleeding vessel using Negus artery forceps and Negus ligature carrier. In this method after the ligature is tied around the Negus artery forceps the free ends of the ligature are wrapped around the fingers of both the hands. The knot is then pushed down into the tonsillar fossa using a Negus ligature carrier. This requires considerable practice and juggling movements of the hands since both the hands are occupied in holding the free ends of the ligature.

To overcome the problem of holding the free ends of the ligature, a ligature holding forceps has been devised and used successfully at our hospital.

The forceps consists of two straight artery forceps joined together by a cross linkage, one set of finger loops of the forceps are welded together to provide additional stability (Fig-1). The free ends of the knot which is tied around the Negus artery forceps is held by this ligature forceps instead of the fingers of both hands. The ligature forceps is held in one's hand while the other hand is free to hold the Negus ligature carrier and push the knot down into the tonsillar fossa for achieving haemostasis.

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Fig. 1: Mehtas ligature forceps for tonsillectomy

REGIONAL BLOCKS IN EXTREMITY TRAUMA

Dear Editor,

I would like to congratulate the authors of the article "Regional Blocks in Extremity Trauma" [1]. They have managed to tide over a crisis and provide relief to injured patients in the absence of an anaesthesiologist. Use of bupivacaine and lignocaine, as a combination is well known. The delayed onset along with prolonged duration of action of bupivacaine and the rapid onset along with shorter duration of action of lignocaine are symbiotic and result in a good rapidly acting and prolonged block. The minimum blocking concentration of a local anaesthetic is defined as the lowest concentration, which will block the nerve in vitro. It depends on nerve fibre size, temperature, pH of the drug, amount of surrounding connective tissue, stimulating frequency and a host of other factors [2]. The recommended dose of lignocaine for analgesia is 0.5% to 1.0% and that for anaesthesia is 1.0% to 2.0% [3]. The authors have used a mixture of 25 ml of 0.5% bupivacaine and 5 ml of 2% lignocaine in case No 1 and 20 ml bupivacaine (0.5%) along with 2 ml lignocaine (2%) in case No 2. The concentration of lignocaine, in the mixture would be 0.33% in case No 1 and 0.18% in case of No 2. In both these cases the concentration is well below the clinically effective dose.

The authors have thus not been able to capitalise on the important advantage of lignocaine, namely, rapid onset of action. When one uses lignocaine (2%) as a constituent of the mixture, the amount of lignocaine required to produce anaesthesia will have to be at least 50% of the total volume of the mixture. Use of such a large volume of lignocaine will dilute the other local anaesthetic in the mixture-bupivacaine.

We have been using a mixture of bupivacaine and lignocaine for our field, plexus and local blocks. We use lignocaine (5.0%), which

is available for spinal anaesthesia as a constituent of the mixture. The advantage of using this preparation of lignocaine is that small quantities are required and the final concentration of both bupivacaine and lignocaine are well above the minimum blocking concentration.

A typical example would be use of 24 ml of bupivacaine (0.5%) and 6 ml of lignocaine (5.0%). This would give us concentration of 0.4% for bupivacaine and 1.0% for lignocaine in the mixture. This solution is also very effective for epidural and caudal blocks.

We recommend the use of lignocaine (5.0%) instead of lignocaine (2.0%) as a constituent of mixture of local anaesthetic agents. This will allow the advantages of both bupivacaine and lignocaine to be clinically manifest and result in a rapidly acting yet prolonged block.

References

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