distant from main hospital site, make the GA section fraught with risk and potential danger. Would the use of a familiar drug such as propofol not create a safer environment, improve patient care and limit accidental awareness?

Declaration of interest

None declared.

Reference

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Reply from the authors

The obstetric RSI

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Editor—We thank Drs Nasser and Babatunde for their interest in the NAP5 project. We agree that NAP5 shines a light particularly on obstetric practice - confirming as it does that obstetric anaesthesia is the anaesthetic subspecialty with the highest rate of accidental awareness during general anaesthesia (AAGA). Obstetric anaesthesia was associated with a 12-fold over-representation in cases reported to NAP5 compared with the accompanying activity survey.[1 2] The cause of this increase in AAGA is likely multifactorial - as discussed in some detail in the report.[2] Obstetric general anaesthesia includes an increase in the following risk factors identified in NAP5 - use of thiopental, RSI, omission of opioids, obesity, difficult airway management, high rates of emergency anaesthesia, performed at night, by trainees and a very short time between induction and the start of surgery.

The issue of thiopental and RSI extends beyond obstetric practice. Use of thiopental was 8-fold higher in reports of AAGA to NAP5 than in general use in the activity survey and use of RSI was 6-fold higher. In contrast propofol as an induction agent was modestly under-represented (10% fewer cases than expected from the activity survey). The data support the contention that thiopental is reserved for RSI - in the activity survey thiopental was the induction agent for <3% of cases, and 87% of uses were for RSI. In the activity survey 33% of RSIs were with thiopental, but 92% of reports of AAGA after RSI included thiopental. Both thiopental and RSI were used for >90% of Caesarean sections in the activity survey - and in all reports of AAGA reported to NAP5. It was noted in review of the cases that the dose of thiopental was often low - and it is possible that this is a consequence of increasing lack of familiarity. We are aware that propofol is indeed the drug of choice for obstetric practice in many countries outside the UK and the activity survey confirms it is the commonest drug used for RSI in the UK in non-obstetric practice - 69% of cases.

In the NAP5 report we recommend that 'anaesthetists should exercise caution when using thiopental for RSI' (recommendation 8.5) and that 'research or debate should establish whether there are benefits to using thiopental that counter the disadvantages identified in this Report' (research implication 8.6).[4] Specific to obstetric practice we recommended that 'studies are required to further establish the optimal dose of thiopental for obstetric induction' (research Implication 16.2) and that 'further studies are required to assess the effect of propofol as an anaesthetic induction agent in the compromised mother and fetus' (research implication 16.3).[3]

We judged it was not the role of NAP5 to direct obstetric anaesthetists and trainees in detail how to give an obstetric anaesthetic. We now hope that the use of thiopental for RSI in obstetric and non- obstetric practice, including where necessary further research, will be considered further by those national organizations which advise on such areas of practice and by those commissioning research.

Declaration of interest

All authors were members of the NAP5 review and steering panel committees. TMC is an associate editor of the *British Journal of Anaesthesia*.

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