CORRESPONDENCE

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In reply: — We appreciate Dr. Linko's interest in our study and hope that our answers will clarify his inquiries.

1) The screen filtration pressure (SFP) extrapolations were obtained from the straight portion of the Bentley transducer which is linear to 900 torr, not 500 torr.

2) Harp et al. demonstrated a profound increase in microaggregate formation, measured by screen-filtration pressure between day 6 and 8 of storage. Thereafter, a slow, persistent rise in SFP was apparent through day 21. We have assumed that three-to-six-week-old blood would continue to accumulate microaggregate debris at a similar slow rate.

3) We agree that filtration of erythrocyte concentrates cannot be exactly compared with whole-blood microfiltration. For just that reason, we studied filtration of erythrocyte concentrates since our hospital rarely uses whole blood.

4) Although the standard 170-μm filter is changed after each unit of blood passes through it, we do not recommend this practice. We agree that there is no reason to discard the 170-μm filter after a single use.

5) We concluded that fine-screen filtration was safe, not just because of our own data but because of the studies by Marshall et al. to which we referred.

6) We agree that the study by Duetschi, et al. suggests that filtration through a 40-μm mesh filter offers no significant protection to pulmonary function in man. Their in vitro findings are qualitatively similar to ours since only 12 per cent of their microaggregates were filtered. We agree that the more efficient filters need to be studied during massive transfusion just as Duetschi et al. have done with the 40-μm mesh filter. Since our studies show that the more efficient filters (Bentley®, Fenwal®, Biostep®) allow excellent flow rates of packed cells infused under pressure, studies of these filters are needed.

7) It might be possible to transfuse buffy-coat free blood as suggested by Högan et al., but preparation of blood with the saline-adenosine-glucose additive is not yet licensed for use in the United States, nor is it available to us through our blood bank.

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REFERENCES


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Anesthesiology

The Use of Saline for the Differential Diagnosis of Pain Mechanisms

To the Editor: — The recent Clinical Report by Benzöen et al. documents again that the conduction of nerve impulses can be blocked by agents other than those usually associated with local or regional anesthesia. While it is true that we have recommended differential neural blockade “to differentiate psychogenic, sympathetic, and somatic sensory-mediated pain,” we have never stated that “pain relieved by injection of physiologic saline solution is regarded as psychogenic in origin” categorically, as stated by the authors. We have been extremely careful to state that “relief after the injection of saline suggests a psychogenic basis for the pain,” and have indicated clearly that “to allow accurate interpretation of the results of differential blocks, in addition to noting the subjective response of the patient, objective evaluation of sensory (pin-prick), motor (mobility), and sympathetic (skin temperature, oscillometry, psychogalvanic response) func-