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course during the treatment cycle as reported by the patients.

Despite the methodologic problems of any retrospective case review, especially in this particular population, we believe our results suggest the importance of further investigation of the use of conjugated estrogens as prophylaxis against pregnancy.

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SAFETY OF LOCAL VERSUS GENERAL ANESTHESIA FOR SECOND-TRIMESTER DILATATION AND EVACUATION ABORTION

To the Editor:

Mackay et al, in their study of complications of second-trimester abortion, "Safety of local versus general anesthesia for second-trimester dilatation and evacuation abortion" (OBSTET GYNECOL 66:661, 1985), attribute a high incidence of serious febrile morbidity (fever of 38C or higher for three or more days) and hemorr! age requiring transfusion to the use of general anesthesia, as opposed to local anesthesia for this procedure. Although current evidence suggests that general anesthetic agents (especially nitrous oxide) can produce a dose-dependent depression of production and mobilization of polymorphonuclear leukocytes, there is no evidence that the incidence of postoperative infection can be influenced by the choice of anesthetic agent or technique. Indeed, the incidence of postoperative infection seems more likely to be related to surgical trauma and the associated release of cortisol and catecholamines, which are known to inhibit phagocytosis.

In applying the broad category of "general anesthesia" to a group of patients, the authors assume that all general anesthetic agents or techniques are the same. While it is true that a potent inhalation agent like halothane or trichlorethylene will produce dose-dependent uterine relaxation and therefore increased uterine bleeding, clinical experience has shown that nitrous oxide has little effect on uterine contractility.[1,2] In fact, blood losses remained at low levels even when abortions were performed at 14–16 weeks of gestation when nitrous oxide combined with only intravenous anesthetic agents was given for anesthesia (mean blood loss 58 mL), as opposed to paracervical block anesthesia (mean blood loss 25 mL).[2] This is hardly a situation requiring transfusion in the "general anesthesia" groups.[2,3] We believe that Mackay et al come closer to the real problem when they state that "hemorrhage occurring with general anesthesia may also be the result of the longer duration and vigor of curettage that is likely to occur with the patient asleep."

In the absence of randomized, prospective, controlled studies, and with the current state of knowledge of anesthetic influence on postoperative infection and uterine hemorrhage being contrary to the authors' opinions, we feel that they have not proved their contention.

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In reply:

We would like to thank Drs. Heyman and Barton for their comments on our article, "Safety of local versus general anesthesia for second trimester dilatation and evacuation." The Joint Program for the Study of Abortion (JPSA) was designed to look at the short-term complications of induced abortion. Because of the nature of the study, the specific anesthetic agents were not specified. We recognize that all anesthetic agents are not the same. Presumably at least some of the patients who experienced hemorrhagic complications received agents such as halothane or trichlorethylene,

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