Table I. Colony-forming units on sedimentation plates

	Ultraclean zone (n = 30)	Instrument trolley (n = 15)	Periphery (n = 30)	Interposed person (n = 30)
Colonies per plate				
Median	0	0	3	5
Range	0 to 2	0 to 2	0 to 7	0 to 22
Mean	0.27	0.33	3.43	7.23
Colonies per m ² /hour				
Mean	74	91	947	1994

The plates outside the ultraclean zone had a mean count of 3.43 colonies per plate, ten times more than in the ultraclean zone ($p < 0.001$). The plates in the ultraclean zone with intermittent interposition had a mean count of 7.23 colonies per plate, 27 times more than those without interposition ($p < 0.001$) and twice as many as those outside the ultraclean zone ($p = 0.009$; Table I).

Discussion. Sedimentation plates offer a better assessment of direct bacterial fallout into a wound than volumetric analysis of air contamination. The sedimentation rate outside the ultraclean zone was similar to that reported for conventionally ventilated theatres (Scheibel, Jensen and Pedersen 1991) but the interposition of head and shoulders into an ultraclean air flow produced double that rate. The size of the increase produced by interposi-

tion may explain some of the contradictory results for infection rates in ultraclean air. Our study suggests that a surgeon who leans over a wound in vertical-downflow ultraclean air can expect a 27-fold increase in direct wound contamination. In operating positions in which interposition is frequent, body-exhaust suits may be especially advantageous.

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A MOBILITY PROGRESS CHART

G. M. SLOWIK, C. L. COLTON

There is no simple way of recording and displaying the progress or the lack of it of a patient who is mobilising after an operation or a period of bed-rest. We have designed a chart which provides such a graphic display.

Method. We grade mobility as follows:

- 00 - confined to bed,
- 0 - able to sit out on a chair,
- 1 - uses a frame for support,

- 2 - uses either 2 crutches or 2 sticks,
- 3 - uses a single crutch or cane,
- 4 - independent with no aids.

The letters 'A' and 'I' are used to denote Assisted or Independent mobilisation, and the amount of weight-bearing is recorded by the standard notation: NWB (non-weight-bearing), PWB (partial), and FWB (full).

This information can be noted on a 'MOBILITY CHART' (Fig. 1) which can be included in the standard bedside charts. We used this chart for 100 consecutive patients after lower-limb surgery, and found it to be extremely valuable in the postoperative period.

Discussion. The chart gives an instant impression of postoperative walking ability, and lack of progress is apparent. The grading system allows for ease of communication between medical staff, nurses and physiotherapists, and the chart provides a permanent record of progress. It also helps to motivate the patient towards higher levels of recovery.

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MOBILITY PROGRESS CHART

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Diagnosis: OSTEoArthritis

Operation: T. H. R

Grade	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
4	Independent																																
3	Independent Assisted																																
2	Independent Assisted									X	X	X	X	X	X	X	X																
1	Independent Assisted				X	X	X	X	X																								
0	Independent			X																													
00	Independent	X	X																														
Weight-bearing				P	P	P	P	P	P	P	P	P	P	P	P	P																	
Joint R.O.M.																																	
Distance				200	400	500	800	1000	1100	1200	1500	1800	2000	2200	2400	2600	2800																
Stairs																																	

RECORDING MOBILITY PROGRESS: Mark the level of mobility achieved each day by placing an "X" on the independent (——) or assisted (——) line corresponding to the appropriate grade.

For weight bearing, insert N, P or F (Non-weight bearing, Partial weight bearing, or Full weight bearing.)

Fig. 1

The chart makes it obvious that the patient was using a frame, and needing assistance for partial weight-bearing on day 4. She became independent of assistance on day 7. Walking with two supports started on day 9, but there has been no progress since then. On day 9, for example, she would be classified as grade 2A.

ANAPHYLAXIS AFTER INTRA-ARTICULAR INJECTION OF BUPIVACAINE AND METHYLPREDNISOLONE

JONATHAN M. HOPPER, SIMON R. CARTER

We report a case of acute anaphylaxis after an intra-articular injection of local anaesthetic and corticosteroid.
Case report. A 58-year-old Asian man with intermittent pain due to mild osteoarthritis of the left knee attended

as a day case for an intra-articular injection. He had no history of any allergic reaction or aspirin sensitivity. The intra-articular injection of 10 ml of 0.5% bupivacaine (Marcaine; Astra Pharmaceuticals, Kings Langley, UK) and 80 mg of methylprednisolone (Depo-Medrone: Upjohn, Crawley, UK) was performed in an anaesthetic room by an aseptic technique, which avoided intravascular injection by prior aspiration.

Within ten minutes of the injection, the patient developed acute dyspnoea and complained that his skin was "burning up". He had bronchospasm, tachycardia, hypotension to 90/50 mmHg as compared with 145/80 mmHg before injection, profuse perspiration and inflammation of the conjunctivae.

He was tilted head-down and given oxygen by a

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