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*In Reply:*—Our case occurred 4 yr ago, when doses of intrathecal morphine (ITM) were considerably larger than in current practice.<sup>1,2</sup> Although it may be entirely correct that Abouleish's supposition that facial pruritus rather than ITM *per se* may be the etiologic factor in reactivating oral herpes simplex virus (HSV), we believed that we should report our observations in view of the findings of Crone *et al.*, who have described a 10–14% incidence of oral HSV following epidural morphine in parturients.<sup>3,4</sup> Why there should be such a significant difference between patients receiving intrathecal or epidural morphine is unclear. We are surprised by the lack of correlation between the administration of ITM and oral HSV in Abouleish's extensive experience, but submit that our observations do not conflict with his for two reasons.

First, with our high dose of ITM, the cerebrospinal fluid concentrations of morphine diffusing rostrally to the brainstem and particularly the region of the trigeminal nuclei would be anticipated to be greater and thus more likely to initiate pruritus and/or reactivate latent HSV in trigeminal ganglia.

Second, the addition of local anesthetic agents to spinal opioids (as is Abouleish's practice) may reduce the incidence of pruritus in trigeminal dermatomes,<sup>5</sup> although this has never been formally evaluated.

We believe it is premature to conclude that ITM as a cause for herpes simplex should be "scratched out," in light of the strong association, be it direct or indirect, of HSV and epidural morphine.<sup>3,4</sup> We would welcome further observations in this area and concur with Abouleish that until further information is available, ITM in low doses (0.2 mg) should continue to find a useful place in obstetric anesthetic practice.

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### Value of the Activated Partial Thromboplastin Time for Preoperative Detection of Coagulation Disorders Not Revealed by a Specific Questionnaire

*To the Editor:*—The current trend in the preoperative evaluation of bleeding risk in surgical patients is toward a two-step assessment. The first step includes a detailed questionnaire on hemostatic history and an evaluation of the true surgical hemorrhagic risk. A positive history in turn indicates the need for a second step, which consists of directed laboratory tests.<sup>1,2</sup>

This approach relies on the hypothesis that history, at a lower cost than laboratory tests, has a sufficient sensitivity in detecting coagulation abnormalities and subsequent bleeding risk. To assess this hypothesis we carried out a prospective study on 4,141 adult surgical patients recruited over a 3-yr period (1985–1987). The study included all the patients admitted for general and vascular surgery without known acquired or congenital coagulopathies, who were not taking medication affecting hemostasis, had no conditions affecting coagulation, and were not hypovolemic, and who were able to reply to a structured questionnaire. Preoperative hemostatic evaluation included a specific questionnaire about hemostatic function, a clinical examination, and laboratory screening tests for bleeding time, platelet count, activated partial thromboplastin time (aPTT), prothrombin time (PT), and fibrinogen assay. For the chronometric tests (aPTT and PT), results outside the normal range were checked by a second test. Only the second test

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result was taken into account. Because a prolonged PT or aPTT cannot discriminate between a deficit in a coagulation factor and the presence of anti-factor antibodies, further tests were carried out to determine the nature of the coagulopathy.

Twenty patients were found to have an abnormal hemostatic screen; in this group, only 3 patients had a history of minor recurrent bleeding. One abnormality was detected by a prolonged PT, and 19 were detected by a prolonged aPTT. The other laboratory tests were normal. Among these 20 patients with abnormal coagulation tests, 8 presented a potential hemorrhagic risk: 3 patients had a deficit in factor XI; 1 had anti-factor VII antibodies; and 4 had von Willebrand's disease with VIII Rco < 30%.

In our series, only three patients with a coagulation disorder gave a positive history by questionnaire, and it could be argued that only these three patients presented a bleeding risk. However, it should be born in mind that not all patients may have been exposed to situations that would reveal bleeding. Surgery is a more critical situation, and it may upset an already precarious hemostatic balance in the patient.<sup>3</sup> On the other hand, aPTT led to the detection of 95% coagulation abnormalities, although the true bleeding risk of these abnormalities could not be assessed since patients at risk were receiving preventive