through the skin and soft tissues. We believe that this maneuver is useful when method 3 fails, for example, in obese patients, and safer since deflation of the cuff is not required. Furthermore, this maneuver provides a simple safe way of tube position verification at any time during the endotracheal intubation.

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A Challenge to the Use of *d*-Tubocurarine Prior to Succinylcholine in Obstetrics

To the Editor:—May I present a challenge to your readers? I have noted over the years the repeated advocacy—especially in the North American literature—that an induction dose of suxamethonium be preceded by a small dose of intravenously administered *d*-tubocurarine. The rationale of this measure appears to be that the nondepolarizer prevents, in the obstetric patient, certain undesirable effects of suxamethonium: generalized fasciculations, with consequential increase in intra-abdominal pressure likely to enhance the prospect of passive regurgitation, and, subsequently, postoperative muscle pains.

I have reasonably well kept records of some 7,000 general anesthetics given for cesarean section in my service since 1968, and the recollection of close on 2,000 similar anesthetics personally administered before that date, and in none of these cases was the induction dose of 100 mg suxamethonium preceded by a nondepolarizer. Fasciculations, if evidenced at all, have almost always been of a very minor character, and never of an extent considered likely to pose the threat of passive regurgitation up the esophagus. Each of our patients is interviewed at least once subsequent to the day of operation, and the incidence of reported muscle pain is approximately 9%—in the great majority of these cases the reference is to mild discomfort in the shoulders or around the lower chest; in fewer than one in a thousand does the mother describe feeling "bruised all over."

I appreciate, as Katz *et al.*[1] showed many years ago, that North American patients, when treated in their own environment, respond differently to muscle relaxants than do British patients treated in the U. K., but I doubt that this contrast is pertinent to my current thesis. I believe that the prior administration of *d*-tubocurarine as described is a pharmacologic trespass possessing no merit, and invokes the hazard of unnecessary delay, plus the avoidable expense of an extra syringe and of the drug itself. Could any of your readers present a reasonable and compelling case for its continuance in obstetric anesthetic practice?

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A Patient Transfer Method: Try It, You'll Be Glad You Did

To the Editor:—We recently have encountered a pleasingly simple and inexpensive variation of a technique for transferring patients from the operating table to a stretcher or bed. The technique follows the example of roller/conveyor devices but uses, instead, the ubiquitous green (the color doesn't matter) garbage bag. The patient initially is rolled, using the draw sheet, 45–60 degrees away from the side to which transfer is to be

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