More about d-Tubocurarine and Succinylcholine in Obstetrics

To the Editor—We feel Marx and Bassell have failed to present a reasonable and compelling case for the use of curarisation prior to suxamethonium. In the United Kingdom the technique rarely is used in obstetric anesthesia because of the following reasons:

1. Some patients are exquisitely sensitive to small doses of d-tubocurarine: double vision, inability to swallow and a feeling of being unable to breathe can occur—not a good thing in an anxious patient.

2. A larger dose of suxamethonium must be used to produce ideal conditions for intubation and may increase the risk of bradycardia.

3. If no fasciculations occur, where is the end point when one can begin intubation? Has the suxamethonium reached the muscles and been effective?

Smith et al. has reported an increase in intragastric pressure but has noted a concomitant increase in lower oesophageal sphincter tone causing a net slight increase in barrier pressure after suxamethonium; this response, however, may be attenuated in pregnancy.

Oxygen consumption rises in anesthetized dogs during suxamethonium infusion not after a single bolus in healthy patients.

Like Crawford we have not found postpartum suxamethonium pains to occur often or create any problems with the mother.

Our advice would be to keep the technique for emergency obstetric anesthesia as simple as possible.

R. H. GODDARD, M.B., Ch.B.
Department of Anesthesia
Bristol and Weston Health Authority
Bristol Maternity Hospital
Southwell Street
Bristol BS2 8EG
England

REFERENCES


(Modified Oral Airway for Fiberoptic Bronchoscopes

To the Editor—The techniques employed to perform routine bronchoscopy have changed as new equipment has been introduced and perfected. The development and use of fiberoptic instruments has limited the use of the rigid bronchoscope in recent years. This has encouraged modifications in anesthesia technique. Previously, an awake although sedated patient breathed spontaneously. The use of a fiberoptic bronchoscope allows the anesthesiologist to employ general endotracheal anesthesia with the use of muscle relaxants when indicated. This permits a more meticulous examination of the tracheo-bronchial tree by the operating surgeon as the airway is secured. The length of the procedure generally is not a problem because the patient is anesthetized and properly ventilated.

The optimum position of the endotracheal tube for ease of bronchoscopy is in the midline. In the course of thousands of fiberoptic bronchoscopies, we found it quite difficult to maintain this midline position during the procedure, even when heavy taping was employed. Additionally, heavy taping was a problem if the endotracheal tube needed rapid adjustment during the procedure. Since we usually employ an oral airway during bronchoscopy, it was decided to modify the airway to allow