

economical use of expensive drugs that may only have short lives in solution, *e.g.*, sodium nitroprusside.

Dr. E. P. MCKIERNAN
*Department of Anaesthetics
Christchurch Public Hospital
Christchurch, New Zealand*

REFERENCES

1. Tanaka K: A simple nomogram for determining drug infusion rates. *ANESTHESIOLOGY* 62:99, 1985
2. Webb TD: Intravenous infusing: Making life easy. *ANESTHESIOLOGY* 59:482, 1983
3. Kondo K: Vasoactive drug infusion: Making life easy. *ANESTHESIOLOGY* 60:617, 1984

(Accepted for publication May 21, 1985.)

Anesthesiology
63:460, 1985

A Caution on Vecuronium Priming

To the Editor:—We read with interest the recent report by Schwarz *et al.*¹ on the priming principle for tracheal intubation with vecuronium.

Schwarz *et al.* caution that a 20 $\mu\text{g}/\text{kg}$ priming dose may cause significant paralysis if administered to awake patients. They imply that a 15 $\mu\text{g}/\text{kg}$ dose is safe, since in their study of 10 awake premedicated patients, the patients "experienced no discomfort."

Engbaek *et al.*² recently studied the effects of 15 $\mu\text{g}/\text{kg}$ vecuronium on awake nonpremedicated patients and found decreases in train-of-four to 0.57, 0.58, 0.59, and 0.82 with considerable subjective symptoms in four patients. This prompted them to discontinue their study at this dose range before including the 10 patients anticipated. They conclude that doses higher than 10 $\mu\text{g}/\text{kg}$ are not well tolerated and they report a patient in whom 5 $\mu\text{g}/\text{kg}$ caused a dangerous degree of paralysis.

We agree with Schwarz *et al.* that whenever a priming technique is used, provisions for immediate induction of anesthesia in patients intolerant of this procedure is mandatory. Administering the priming dose immediately after the intravenous has been started, as suggested,¹ may be imprudent if the patient is not yet in the operating room or may not be closely watched.

In those patients who require rapid-sequence inductions

in whom succinylcholine is contraindicated, we recommend the use of a single large dose (0.2 mg/kg)³ of vecuronium on induction.

Further studies are necessary to determine what priming doses are well tolerated and whether these reduced doses confer a significant enough hastening of relaxation to justify their risk and the increased time necessary for induction.

MITCHEL SOSIS, M.D., PH.D.
*Assistant Professor of Anesthesiology
Thomas Jefferson University
Philadelphia, Pennsylvania 19107*

REFERENCES

1. Schwarz S, Ilias W, Lackner F, Mayhofer O, Foldes FF: Rapid tracheal intubation with vecuronium: The priming principle. *ANESTHESIOLOGY* 62:388-391, 1985
2. Engbaek J, Howard-Hansen P, Ording H, Viby-Mogensen J: Precurarization with vecuronium and pancuronium in awake, healthy volunteers: The influence on neuromuscular transmission and pulmonary function. *Acta Anaesthesiol Scand* 29: 117-120, 1985
3. Bencini A, Newton DEF: Rate of onset of good intubating conditions, respiratory depression and hand paralysis after vecuronium. *Br J Anaesth* 56:959-965, 1984

(Accepted for publication May 21, 1985.)

Anesthesiology
63:460-461, 1985

Concerning the Acceptability of Awareness during Surgery

To the Editor:—In his editorial, "Awareness during Surgery," Blacher¹ supports the view expressed by Bogetz and Katz² concerning a willingness to accept that total oblivion of consciousness in traumatized patients may not

always be achievable. We object to these statements since the American Society of Anesthesiologists guidelines for patient care note that Anesthesiology includes "the management of procedures for rendering a patient insensible