

**TITLE:** DILUTIONAL HYPONATREMIA ASSOCIATED WITH GLYCINE IRRIGATION IN INTRAUTERINE ENDOSCOPIC SURGERY  
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The evolution of the natremia was studied in 20 ASA I women, aged between 23 and 76 years (mean age 37), undergoing intrauterine endoscopic resection through a double flow resector with glycine 1,5% as a distention device. The pressure of irrigation was not assessed; the volume of glycine solution measured at the end of the operation was variable with the needs of the operator and ranged between 1,5 and 4,5 l. The operative time did not exceed one hour. The patients did not receive any particular preoperative preparation. A venous blood sample was obtained every 20 minutes peroperatively and every hour postoperatively for analysis of sodium levels. A standardized anesthetic protocol was administered to all the patients: perfusion of propofol associated with phenoperidine and atracurium in bolus.

A close relationship was clearly established between volume of glycine administered and the variations of the natremia (DNA, mean + SD:  $2,44 \pm 1,17$  mmol.  $l^{-1}$  for volumes inferior to 1,5 l ( $n=9$ ),  $5,5 \pm 0,95$  mmol.  $l^{-1}$  for volumes between 1,5 l and 3 l ( $n=7$ ),  $9,75 \pm 2,48$  mmol  $l^{-1}$  for volumes superior to 3 l ( $n=4$ )). No neurological or cardio-respiratory accidents were noted. The hyponatremia appeared between the 20 th and the 40 th minute and was much earlier when the volume administered was important and probably function of the pressure of irrigation. When the volume was inferior to 1,5 l the hyponatremia was almost no existent, but it was constant when the volume was superior to 3 l. Two hours after the end of the endoscopic surgery, the values of natremia returned to the normal level spontaneously.

The intrauterine pressure during the irrigation appears to be the most important factor in the genesis of the hyponatremia associated with intra-uterine resection; it must be reduced as much as possible either by using small volumes of irrigation or by a preoperative cervical dilatation that could optimize the operative conditions.

A1052

**TITLE:** EFFECT OF SMOKING ON DURATION IN RECOVERY ROOM  
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With increasing numbers of surgeries, and pressure to do more as outpatients, coupled with a need to streamline medical costs, people have focused on length of recovery room (RR) stay. Makers of new muscle relaxants, narcotics, sedatives and inhalational agents suggest their products have rapid recovery. The multifactorial nature of this problem (patient past medical histories, surgical procedures, anesthetic techniques, etc.) has made examination difficult.

327 surgical patients were studied including all surgical procedures excepting open-heart and obstetrical, regardless of time, patient age, or complexity. During surgery, a check list of approximately 35 variables such as the type of surgery, type of anesthesia, drug usage, fluids invasive monitoring, age, and medical history was completed. RR variables were completed in the RR. Data were analyzed using ANOVA and CHI square analysis with a significance of .05.

RR time varied from 15 min to five hr with a median of 75 min. Anesthesia length was most closely correlated with length of stay in RR. While 40% of patients with anesthesia lasting under an hour were in the RR < 1 hr; only 3% of patients with anesthesia >2hr were in the RR for this period. Only 4% of patients with short anesthesia time required RR stays of <2 hr, 25 % of the long anesthesia group required this lengthy stay.

All other variables such as ASA class, anesthesia type, surgery were unrelated to length of time in RR or found to be secondary to anesthesia time. The only independent factor was smoking history. While there were comparable ratios of smokers in all groups tested and they were equally distributed across length of anesthesia times, there was a marked difference with length of RR stay. 38% of non-smokers were found to have RR stays of < 1 hr compared to 23% of smokers. Only 7% of the non-smokers required longer RR stay compared to 19% of the smokers. These findings were significantly different and unrelated to any other tested factors.

We conclude that there is a relationship between smoking and length of time in Recovery Room. It is not known whether this change varies from heavy to light smokers and whether short-term abstinence in elective surgical procedures can improve these figures.