side. He was then log-rolled onto his back. There were no significant hemodynamic changes as a dense sensorimotor block to T4 level developed. The gastrostomy began 5 min later and was followed by the inguinal hernia repairs. There were no episodes of inadequate anesthesia, desaturation, apnea, or hemodynamic instability. The child received normal intravenous hydration through a preexisting intravenous catheter. No sedatives were required. He was returned to the pediatric intermediate care unit. His residual block began to recede approximately 2.5 h after block, and by 4 h after block, he exhibited baseline sensorimotor function.

We chose a spinal anesthetic after considering risks and benefits. In reviewing the current literature, much attention has been focused on considering peripheral lower extremity and lower abdominal surgeries as appropriate for subarachnoid blockade in pulmonary compromised infants. Specific reference to upper abdominal surgery, particularly as regards pulmonary function intraoperatively and postoperatively, is lacking. Rice et al. have researched the effect of subarachnoid block in high-risk infants undergoing lower abdominal surgery and suggest that, although breathing mechanics are altered, there are no significant changes in transcutaneous carbon dioxide or arterial oxygen saturation with sensorineural block to T4 levels. Given this child’s history of difficulty in separation from mechanical ventilation, we elected to attempt subarachnoid block and proceed to tracheal intubation and a combined general and regional anesthetic if required.

Our case suggests that subarachnoid block may be an acceptable anesthetic for relatively simple upper abdominal surgery, allowing many of the same benefits portended for lower abdominal and peripheral lower extremity surgery.

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Reference
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Anesthesiologists and Substance Abuse

To the Editor—While Schmidt and Schlesinger are to be commended for their attempts to bring greater accountability to the distribution of controlled substances at their hospital, they are to be loudly condemned for their statement, “Substance abuse is more common among anesthesiologists than among any other medical specialty,” citing Spiegelman et al.’s 1984 paper. What this source states is that anesthesiologists are over-represented in substance abuse treatment programs, but it is a vast leap of science and fact to say this equates to higher rates of abuse among anesthesiologists than any other medical field. What it may mean is that anesthesiologists are more likely to recognize a problem in themselves and self-refer to those treatment programs.

Among the many things we as anesthesiologists must be vigilant of is the transmutation of rumor and innuendo into fact. If we are not, then we can expect those less expert than ourselves to worry needlessly about their anesthesiologist citing our own journal as the source of those fears.

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In Reply:—Our reference to Spiegelman et al.’s1 paper was not a “transmutation of rumor and innuendo into fact.” Several anesthesiology textbooks review this and other literature and reach the same conclusion. Berry and Katz2 state, “There are more addictive diseases among anesthesiologists than among any other medical specialty.” According to Arnold,3 “The disease is more common in some spe-
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cialties, especially anesthesiology. . . . . While the magnitude of this difference is debatable, to contend that drug abuse is not serious threat to our specialty is not in the best interest of anesthesiologists or their patients. At Hackensack Medical Center, we found that recognizing the opportunity for abuse and confronting our controlled substance problem directly were the first steps toward decreasing the potential for substance abuse by operating room staff. Implementing a reliable accounting system was the next important step.

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Injection of Pancuronium into the Masseter Muscle for Difficult Reduction of Mandibular Dislocation

To the Editor—I would like to report a heretofore undescribed use of a neuromuscular relaxant. Recently, I was requested to induce general anesthesia in a 37-year-old male patient, height 1.72 m and weight 60 kg, for reduction of bilateral dislocation of the mandibular condyle. The reduction was attempted previously under sedation without success. The clinical and social history of the patient was remarkable for malnutrition, chronic alcoholism, and epilepsy treated with carbamazepine and phenobarbital. In the operating room, another unsuccessful attempt of reduction was made under sedation with 100 µg intravenous fentanyl, and 5 mg midazolam.

Based on a report of injection of pancuronium into the sternocleidomastoid muscle to differentiate central from peripheral torticollis, I injected a neuromuscular blocker into the masseter muscle to obviate the induction of general anesthesia and possible loss of airway control. A dose of 0.05 mg pancuronium in 1 ml normal saline (0.01 of the intubating dose) was injected, 0.5 ml into the body of each masseter, through a single injection site with a 1-ml syringe connected to a 25-G disposable needle (Becton-Dickinson). This allowed an easy reduction of the dislocation of the mandibular condyles within 2 min, while consciousness and airway reflexes were maintained throughout the procedure. The temporomandibular joint was immobilized through a restrictive dressing, and the patient expressed no symptom of weakness or discomfort.

In cases of dislocation of the mandibular condyle, masseter muscle spasm prevents the patient from closing the jaw into normal occlusion. When sedation is not sufficient to allow reduction, anesthesia of the auriculotemporal nerve, or even general anesthesia, has been recommended. However, considering the reason why reduction is difficult (i.e., masseter muscle spasm), I suggest injecting pancuronium into the masseter muscle would be the most reasonable therapeutic measure to be taken in this case, instead of inducing general anesthesia. Great care should be taken while preparing this small dose of pancuronium to avoid generalized muscle weakness.

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