

- with mechanomyography in cat and man. *Dan Med Bull* 1996; 43:301–16
48. Claudius C, Viby-Mogensen J: Acceleromyography for use in scientific and clinical practice: A systematic review of the evidence. *ANESTHESIOLOGY* 2008; 108:1117–40
49. Harper NJ, Martlew R, Strang T, Wallace M: Monitoring neuromuscular block by acceleromyography: Comparison of the Mini-Accelograph with the Myograph 2000. *Br J Anaesth* 1994; 72:411–4
50. Dubois V, Fostier G, Dutrieux M, Jamart J, Collet S, de Dorlodot C, Eloy P, Dubois PE: Philips Intellivue NMT module: Precision and performance improvements to meet the clinical requirements of neuromuscular block management. *J Clin Monit Comput* 2020; 34:111–6

ANESTHESIOLOGY REFLECTIONS FROM THE WOOD LIBRARY-MUSEUM

From Paralytic Poison to Medicinal Marvel: Curare Advances Anesthesia



After extracting curare from vines like *Chondrodendron tomentosum* (left), South American natives stored the tarry toxin in pots (right) and slathered it on arrow tips to slay enemies and prey. Scientists would call the active compound *d*-tubocurarine for the bamboo tubes (right) that held the arrows. In the 1730s, French mathematician Charles Marie de La Condamine became the first to study curare during an Andean expedition to prove Newton's view of Earth as an oblate spheroid—rounder at the Equator than the poles. At the time, he attributed the death of a curare-injected hen to respiratory muscle paralysis. In a famed 1814 experiment, English naturalist Charles Waterton and colleagues used artificial ventilation to keep a curarized donkey alive. But it was not until 1938, when North American explorer Richard Gill imported 12 kg of Ecuadorian curare to treat his own muscle spasms, that the arrow poison would enter anesthetic practice. After E. R. Squibb & Sons acquired Gill's supply and purified it to make Intocostrin (right), former anesthesiologist and Squibb advisor Lewis H. Wright supplied the drug to Canadian anesthesiologist Harold Griffith. The latter soon published in *ANESTHESIOLOGY* his success with Intocostrin for rapid muscle relaxation in 25 lightly anesthetized patients (1942; 3:418–20). And so began a revolution, in which the drawbacks of deep anesthesia—cardiac depression, explosion risk, severe nausea, and prolonged emergence—could finally be mitigated. (Copyright © the American Society of Anesthesiologists' Wood Library-Museum of Anesthesiology.)

Jane S. Moon, M.D., University of California, Los Angeles, California, and Melissa L. Coleman, M.D., Penn State College of Medicine, Hershey, Pennsylvania.