accept K as the symbol for Potassium so why not I for gas flow-rate? Indeed, some “non-initial” symbols will have to be accepted soon in order to relieve the clash of C standing for compliance and for concentration in the blood phase and R for resistance and respiratory exchange ratio.

As the system expands, further clashes will occur and no doubt further changes will be required. For instance, who is going to write $F_{\text{CH}_{4}}$ for the fractional concentration of halothane in inspired gas? But while these changes can, and, indeed, generally must, be left until the need arises, it seems to me essential that the fundamental differences between this system and the mathematical systems used in all other branches of science (use of italics and avoidance of “on the line” suffixes and improper use of symbols such as $\dot{V}$) should be resolved as quickly as possible before they become too heavily entrenched.

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REFERENCES

Sirs,—Thank you for giving me the opportunity to comment on Dr. Mapleson’s letter.

I think his suggestions about the use of italics and inferiors are reasonable and if used in the Journal should cause no confusion.

I do not think his remarks about the correct designation of time derivatives are as sound. I would like to comment on this aspect of his letter in more detail. However, I was not party to the discussion under the chairmanship of Dr. Pappenheimer (Fed. Proc. (1950), 9, 602) which adopted the conventions and I might therefore confuse the issue.

Dr. Mapleson’s comments and suggestions are obviously important outside the immediate field of anaesthesia and I suggest that he write to the members of the original committee or that one of them be invited to comment on his letter.

E. J. M. CAMPBELL

DOSE OF CURARE

Sirs,—Dr. Foster in his letter (Brit. J. Anaesth. (1957), 29, 433) reproaches me for attempting long range diagnosis in my paper on “Doses of Curare” (Brit. J. Anaesth. (1957), 29, 288). In medical literature full case reports are given to enable the reader to visualize courses of events, that he may learn from, and profit by, the author’s experience. If after careful study of a clear and detailed description different conclusions are reached they ought not to be called telepathic.

As Dr. Foster’s case was used to illustrate what I consider to be the effect of large doses of curare there was no need to comment on premedication or to mention that large doses of neostigmine by themselves have a curarizing effect and may summate with the paralytic action of dsc (Chase et al., 1949).

For me it is not difficult to believe that a patient who was unconscious under 75/25 per cent nitrous oxide-oxygen while lying undisturbed on the operating table may partially regain consciousness during intubation. Dr. Foster’s case did not show an isolated reflex movement but was “moving his arms and legs, shaking his head, opening his eyes”. The depth of anaesthesia reached by such a mixture varies considerably in different patients (Nosworthy, 1953).

Though being familiar with the nitrous oxide technique and using it routinely with hardly any supplement for intracranial and lung surgery, in my hands it has not been successful in abdominal operations. In my opinion a given anaesthetic state is the balance between potency of anaesthetic mixture (i.e. gases and drugs) and stimuli. As the stimuli vary the mixture, too, ought not to remain fixed and nitrous oxide ought to be supplemented, e.g. for traction on mesentery or peritoneum. Nosworthy (1953) has raised the question whether certain circulatory disturbances and vasovagal attacks may not sometimes be due to too light anaesthesia, as curarization has little, if any, effect on autonomic reflex activity.

As Dr. Foster rightly states, large doses of thiopentone, pethidine and ether have undesirable side effects, but large doses are rarely needed, and small supplementary amounts will damage the patient less than unsuppressed reflex stimuli. The summary description of my case 1, criticized by him, did not convey the state of a sudden

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