There is no doubt that these volumes offer the finest and most comprehensive surveys of respiratory physiology which have ever been produced. All the authors are experts in their fields and their presentation is almost always beyond any but carping criticism. The marshalling of this vast amount of material must have been an awesome task and editors and authors alike deserve the highest praise. It is, however, inevitably difficult to find particular items amongst half a million words, and the work would seem to justify a more elaborate index. The reviewer also believes that an author index of the type recently used by Aviado* would be valuable in a work of this size.


CORRESPONDENCE

THE URGENCY OF EXPEDITED E.C.G. MONITORING DURING ANAESTHESIA

Sir,—I believe the publication of figure 1 (upside down) in my letter (Brit. J. Anaesth. (1965), 37, 886) justifies a further note. I am presently conducting a statistical analysis of the incidence of muscarinic (wandering pacemaker with or without e.c.g. quiescence followed by a-v nodal rhythm) and nicotinic (premature ventricular) effects of suxamethonium in association with halothane anaesthesia. On three occasions so far I found the continuation of normal rhythmic atrial P-waves in association with apparently fortuitous disappearance of ventricular QRST-waves which do not depend on heart block as judged from the preceding and subsequent lengths of the PR-intervals. I find no previous reference to this intriguing arrhythmia which is not clearly muscarinic or nicotinic. It is illustrated in the bottom trace of the accompanying figure which was obtained from a middle-aged man 1 minute after 40 mg suxamethonium as a first dose during stable halothane anaesthesia in the absence of an endotracheal tube. The patient received no premedication and the induction was with halothane and oxygen only.

The utility of e.c.g. monitoring can be further emphasized by reference to the top tracings in the accompanying figure. It was obtained from a 63-year-old man with ischaemic heart disease who received halothane and nitrous oxide anaesthesia induced by thiopentone and preceded by pethidine and atropine medication. The trachea was intubated with the aid of suxamethonium. He had a fractured femur requiring open surgical fixation. When the tracings to the left of the upper half of the figure were obtained from the V4 chest position, 3 pints of blood were transfused prior to significant further blood loss associated with the surgical procedure. Although the satisfactory blood pressure rose only slightly, it can be seen from the further traces in the upper half of the figure that this augmentation of the blood volume completely corrected the ischaemic and injury currents in his e.c.g. We would not have known about this easily remediable heart morbidity were the e.c.g. not employed.

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