MYONEURAL BLOCKERS AND SUXAMETHONIUM

Sir,—In their recent study of the effectiveness of various pretreatments in preventing suxamethonium fasciculations and myalgia, O’Sullivan, Williams and Calvey [1] used a delay interval of 45 s between pretreatment and subsequent administration of suxamethonium 1.5 mg kg⁻¹. In their Discussion they stated that although others have used a latency of 1–3 min, there is no unequivocal evidence to suggest that this delay is required. Horrow and Lambert [2] sought to determine the optimal interval between administration of tubocurarine and suxamethonium with regard to onset and duration of neuromuscular block, and the presence of fasciculations and postoperative myalgia. Intervals studied were 0, 1, 3, 5 or 7 min, and pretreatment interval was found not to affect onset or recovery from blockade, or the incidence of myalgia. Fasciculations were blocked with an interval of 3 or 5 or 7 min, but not with 0 or 1 min, and they concluded that 3 min appeared to be the optimal time interval.

O’Sullivan, Williams and Calvey [1] concluded that pancuronium had a greater effect on myalgia, and that it decreased postoperative muscle pain significantly at 24 and 48 h compared with gallamine or suxamethonium pretreatment. Before accepting this conclusion, more information is required concerning the four (relatively small) treatment groups with regard to the distribution of type of surgical procedure undertaken. It has been reported [3], and we have found (own published data), that the incidence of postoperative myalgia in female patients after diagnostic laparoscopy on a day-case basis is similar when vecuronium or suxamethonium is used, suggesting that laparoscopy may not be a good model for the study of suxamethonium myalgia. If there were fewer laparoscopy patients in the pancuronium group of O’Sullivan’s study, this might provide an alternative explanation for their reported findings.

J. B. Eisenkraft
A. Herlich
New York

REFERENCES

A COMPLICATION OF INTERCOSTAL INSERTION OF A CHEST DRAIN

Sir,—A 23-yr-old severely asthmatic patient suffered an acute exacerbation resulting in ventilatory arrest at home. Her trachea was intubated immediately by the General Practitioner and intermittent positive pressure ventilation was commenced. During transfer to hospital ventilation became more difficult, and intermittent positive pressure ventilation was commenced. The patient became deeply cyanosed and she suffered a cardiac arrest resulting in ventilatory arrest at home. Her trachea was intubated immediately by the General Practitioner and intermittent positive pressure ventilation was commenced. During transfer to hospital ventilation became more difficult, and intermittent positive pressure ventilation was commenced. The patient became deeply cyanosed and she suffered a cardiac arrest.

On arrival in the Accident and Emergency Department the patient was noted to have gross subcutaneous emphysema of the upper thorax, neck and tongue. An electrocardiogram showed asystole. Large-bore i.v. cannulae were inserted bilaterally in the second intercostal space in the mid-clavicular line, with some release of air. Bilateral chest drains were