THIOPENTONE-SUXAMETHONIUM MIXTURE

Sir,—I have read with interest Dr Alexander's letter (Brit. J. Anaesth., 43, 591).

The purpose of the technique described in my paper (Khawaja, 1971a) was to reduce the risk of aspiration by producing conditions suitable for early intubation. The dose of thiopentone used (4 mg/kg) was adequate to produce unconsciousness but there is a small chance that patients may be momentarily aware of fasciculations before the action of thiopentone starts. In patients in whom the risk of aspiration is high this small risk of awareness was considered to be acceptable. The technique was used in a total of about four hundred patients. One patient regarded the induction as unpleasant because of awareness of fasciculations before losing consciousness and expressed a desire for a different induction technique to be used for any future operations. About ten other patients were found, mostly on direct questioning, to have been aware of fasciculations but did not consider this to be unpleasant. No patient was aware during intubation and no patient expressed aversion to anaesthesia.

Thompson and Rathod (1968), using suxamethonium alone in conscious subjects, deliberately produced apnoea to a stage of mild cyanosis and a sense of suffocation and during this period used suggestion to condition heroin addicts to produce aversion to the preparation of the drug injection. It is unlikely therefore that the technique described could produce aversion to anaesthesia in a similar manner.

However, in an attempt to eliminate the possibility of awareness of fasciculations the technique has now been modified. A small dose of tubocurarine injected before the barbiturate/suxamethonium mixture prevents fasciculations and hence eliminates the possibility of awareness of fasciculations (Khawaja, 1971b).

A. A. KHAwAJA
Kuala Lumpur

REFERENCES


BRONCHOSPASM DURING ANAESTHESIA

Sir,—May I comment on Dr Bloch's recent letter (Brit. J. Anaesth. (1971), 43, 108) concerning this topic?

Bronchospasm associated with general anaesthesia is uncommon and usually due to inadequate reflex suppression in a susceptible subject. True allergic bronchospasm must be very rare under anaesthesia.

There is little doubt that this patient's wheezing was due to prostatic manipulation as this train of events had occurred when he was awake. It only remains to elucidate the actual mechanism.

Recently attention has been drawn to the fact that fit young men not infrequently faint during routine prostatic examination (Bilbro, 1970; Leading article, 1970). Obviously manipulation of the normal gland produces waves of parasympathetic stimuli via the sacral nerves.

This parasympathetic overactivity leads to bradycardia and hypotension. It is not inconceivable that bronchospasm also could occur in a patient who was so inclined. I wonder if the bronchospasm in Dr Bloch's patient was associated with bradycardia and hypotension? There is another possibility, of course. If the patient was inadequately anaesthetized the increase in the intensity of painful stimuli during prostatic enucleation could have fired off the bronchospasm. However, 0.5 per cent halothane (though less than the m.a.c.) should be adequate when used with 70 per cent nitrous oxide and hyperventilation. This cause would also probably have been associated with some tachycardia and arrhythmias.

The treatment in either case initially is probably to administer aminophylline since established bronchospasm may not respond to a theoretical antidote. Having achieved empirical control, however, one should treat the cause, using atropine or an intravenously administered analgesic (pethidine) to prevent further trouble.

Anaesthetists may wonder why wheezing is not seen more often during prostatectomy.

The widespread use of regional analgesia for this procedure may account for the lack of reflex irritation but one must remember that the vast majority of patients having this operation are much older than Dr Bloch's patient and are actually having a prostatic adenoma or carcinoma removed.

Frequently little normal gland (or its nerve supply?) remains. In this patient an infected, but probably sensitive, gland was removed.

THOMAS S. MORLEY
Detroit

REFERENCES


MALIGNANT HYPERPYREXIAL DEATHS IN A FAMILY

Sir,—With reference to the article by Barlow and Isaacs (Brit. J. Anaesth. (1970), 42, 1072), I would like to point out certain possible overdose of drugs. Pethidine 100 mg and hyoscine 0.2 mg appear an enormous premedication dose for a 10-year-old coloured child (we give one-quarter of this dose). Besides, 250 mg thiopentone as an induction dose after such a heavy premedication also seems a formidable dose. I will be surprised if this patient did not develop respiratory and c.v.s. depression.

V. M. DIVEKAR
Bombay