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).

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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 is rare in clinical practice; the reaction in Dr Bloch's patient was most probably a reflex overreaction of the bronchial tree to an irritant produced by the inhalation of nitrous oxide, especially in the presence of atropine and a high percentage of oxygen. The bronchospasm in Dr Bloch's patient may have been due to the irritation of the bronchial mucosa by the procedure of local anaesthetic injection. Thus the bronchospasm is more likely to be a reflex manifestation of a physical irritation than a direct allergic reaction.

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 very sensitive, gland was removed.

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REFERENCES


MALIGNANT HYPERTHERMAL 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.

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