These results (table I) agree with previous reports (Simpson et al., 1972; Blogg et al., 1973) that fazadinium is a drug with a moderate duration of action. However, the speed of onset of the neuromuscular block was slower than that reported by investigators using larger doses (Colman et al., 1973), being more comparable with those reported by Kean (1975) who used doses and techniques similar to those in this study. Variations in dose would be expected to alter the time course of the drug effect. A similar explanation can be invoked for the clinically insignificant changes in heart rate, which are in marked contrast to the large increases occurring in response to larger dosage (Blogg et al., 1973; Colman et al., 1973; Savege et al., 1973). Our finding that endotracheal intubation was generally easy following a dose of 15 mg was surprising, in view of previous reports (Arora et al., 1973; Blogg et al., 1973). The 2-min delay following the administration of fazadinium and the greater depth of anaesthesia in our study may have contributed to this finding. The use of the degree of recovery of twitch height at 20 min following the relaxant as an estimate of duration of activity, as used in group A, is open to criticism and we therefore estimated the time for recovery from 50% to 75% switch in group B, and again the slope of recovery was similar. We chose a small dose of fazadinium in these patients to allow recovery within a reasonable period of observation.

There would appear to be no difference between the two formulations in the doses used, and our findings in both groups agree broadly with those in other published reports.

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REFERENCES


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Although the administration of pancuronium was closely associated with the cardiovascular collapse, there was no bronchospasm. Sensitivity reactions to pancuronium have been reported (Buckland and Avery, 1973; Clark, 1973; Heath, 1973), but none of these have been fatal, and in all of them bronchospasm has been a marked feature. However, our patient received thiopentone and suxamethonium, both of which have been implicated as causes of cardiovascular collapse (Clarke et al., 1975; Dundee, 1976), although the time sequence would be more in favour of pancuronium.

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REFERENCES

GENERAL ANAESTHESIA FOR NEUROSURGERY

Sir,—It was with great interest that we read the article “General anaesthesia for neurosurgery” by Greenbaum (1976).

With regard to the early diagnosis of venous air embolism, the use of Doppler ultrasound during neurosurgical procedures (Edmonds-Seal and Maroon, 1969) has revealed a frequency ranging from 21 to 39% (Maroon et al., 1968; Edmonds-Seal, Prys-Roberts and Adams, 1970; Michenfelder, Miller and Gronert, 1972). Thus the figure of 3.8% quoted by Dr Greenbaum is too low. Recently we have reviewed 400 neurosurgical procedures performed during the past 5 years with the patient in the sitting position and have noted a frequency of air embolism of 25% detected by the ultrasonic Doppler and verified by aspiration through a right atrial catheter. Thus the Doppler is more sensitive and more accurate than the oesophageal stethoscope under general anaesthesia. We are pleased to note that the technique appears to be gaining in popularity, at least geographically!

We reported this technique in 1975 and again in 1976 (Smith, Lindholm and Klain, 1975, 1976). However, we used a fluidic controlled ventilator (Klain and Smith, 1976) for delivering and controlling the oxygen jet. In addition we measured the airway pressure continuously by the use of fluidic devices. A unique and important feature of our system is that the jet may be set to cut off automatically if the airway pressure is excessive. This technique was used successfully in 28 patients in our initial report and it has been used subsequently in an additional 42 patients, without complication.

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REFERENCES

ANAESTHESIA FOR FIBROOPTIC BRONCHOSCOPY

Sir,—We read with interest the letter by Heifetz and De Mytttenaere (1976) describing the use of a jet catheter technique for fibrooptic bronchoscopy under general anaesthesia. We are pleased to note that the technique appears to be gaining in popularity, at least geographically!

We reported this technique in 1975 and again in 1976 (Smith, Lindholm and Klain, 1975, 1976). However, we used a fluidic controlled ventilator (Klain and Smith, 1976) for delivering and controlling the oxygen jet. In addition we measured the airway pressure continuously by the use of fluidic devices. A unique and important feature of our system is that the jet may be set to cut off automatically if the airway pressure is excessive. This technique was used successfully in 28 patients in our initial report and it has been used subsequently in an additional 42 patients, without complication.

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