CORRESPONDENCE

ATROPINE PREMEDICATION AND RESPIRATORY COMPLICATIONS

Sir,—Jones and Drummond (1981) have shown that premedication with atropine does not influence the frequency of postoperative respiratory complications. However, they do not make a recommendation for routine use, or otherwise, of atropine in premedication. Studies on the effects of atropine administration on ciliary activity have shown conflicting results. Experimental studies in dogs have shown an inhibition of mucociliary transport (Chopra, 1978; King, Cohen and Viires, 1979), but in anaesthetized patients, atropine has been shown to decrease it (Annis, Landa and Lichtiger, 1976).

One could deduce from the report of Jones and Drummond (1981) that atropine was not helpful in the reduction of chest complications after operation. In a survey of anaesthetists (Mirakhur et al., 1978) it was found that one-third of anaesthetists did not use anticholinergic drugs routinely in premedication. A principal reason was that they felt that atropine made the secretions viscid and perhaps difficult to expectorate. The omission of routine administration of anticholinergic premedication does not seem to influence the course of anaesthesia in any adverse manner (Kessell, 1974; Leighton and Sanders, 1976; Mirakhur and Dundee, 1979; Mirakhur, Dundee and Connolly, 1979).

If atropine does not prevent respiratory complications, why use it routinely in premedication in view of the discomfort of a dry mouth and the pain of an i.m. injection?

R. K. MIRAKHUR
R. S. J. CLARKE
Belfast

REFERENCES


INTENSIVE CARE UNIT REVISITED

Sir,—The reaction to being a patient in an Intensive Care Unit is the subject of much discussion and speculation amongst medical and nursing staff. Having spent some considerable time working in I.C.U.'s, both as a registrar in anaesthesia, and in nephrology, I had gathered my own vicarious impressions. The opportunity to gain personal insight resulted from a car accident in which I sustained a number of injuries including a fractured maxilla and facial trauma, despite the protection of a seat belt.

Following assessment in the Accident department I was transferred to a surgical ward, and from there, in anticipation of airway problems, to the I.C.U. The information that I was to be transferred was discussed with me by a number of people, who adopted two distinctly different approaches. The first was the comment that my transfer was a measured response to a recognized problem, and that I could be managed more safely in the I.C.U. Since I was aware of partial airway obstruction, as I believe any tolerably intelligent person would have been, this approach was appropriate. The second, and perhaps understandable, approach was one of apology. I am sure that I have adopted this sympathetic attitude in such circumstances, but the effect is to imply that transfer to an I.C.U. reflects grave deterioration, and is not uncommonly a pre-mortem event. I am certain that the positive approach is better.

I know many of the I.C.U. staff, and I suppose that this was potentially a cause of embarrassment. However, there was a calm acceptance by the nursing staff that I could not care for myself and needed help. I was equally content to be the patient, and the change of relationship was effected without difficulty. Similarly, the medical staff were frank in discussing the anaesthetic risks of surgical reduction and fixation, and were clear about the possible need for a tracheotomy. I was more reassured by their clarity than I would have been by bland reassurance, and again I am sure that this would be the reaction of any patient who was aware of his precarious state.

To my relief tracheotomy was avoided, but the night after operation was frightening when my nasopharyngeal tube became dislodged and I had to breathe through wired teeth and swollen lips. I was terrified, and, interestingly, was much more reassured by the presence of a nurse than I was by the use of monitoring equipment. When the nurse left me to care for another patient I began to panic, and when she returned I was calmed. One can speculate as to whether an understanding of the effect is to imply that transfer to an I.C.U. reflects grave deterioration, and is not uncommonly a pre-mortem event. I am certain that the positive approach is better.

I was left in no doubt that, whilst monitoring devices provided more or less reassurance, monitoring equipment provides more reassurance. However, I am left in no doubt that, whilst monitoring devices may well be essential, a strong nursing presence is of more benefit to frightened patients.

What, then, are my lasting impressions? Nothing startlingly original; only confirmation that clarity of explanation and constant reassurance are essential components of intensive care management. Those who seek to reduce patient-staffing ratios should temper their decisions with humanity.

HUGO MASCIE-TAYLOR
Leeds