CORRESPONDENCE

CUTANEOUS REACTIONS TO ATRACURIUM

Sir,—Many anesthetists have commented on the incidence of cutaneous reactions following the administration of atracurium (Mirakhur et al., 1983; Rowlands, 1983). Some have speculated that these reactions may be the result of histamine release (Philbin et al., 1983). However, a recent study concluded that atracurium has a low potential for causing histamine release and that the clinical signs observed following atracurium do not correlate well with plasma histamine concentrations (Barnes et al., 1984).

In an attempt to elucidate the mechanism of these cutaneous reactions we have assayed plasma for conversion of the C3 component of complement in eight female patients given atracurium 0.3–0.6 mg kg⁻¹. The patients were premedicated with oral lorazepam and anaesthesia was induced with fentanyl 2–5 μg kg⁻¹ and a “sleep” dose of thiopentone. Venous blood was sampled immediately before and 2 min after giving atracurium. Six patients had a cutaneous reaction, but no patient showed any evidence of C3 conversion.

We conclude that complement conversion is not involved in the production of flushing in the majority of patients who react in this way following atracurium.

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REFERENCES

ANAESTHESIA FOR FRACTURED HIP

Sir,—The article on subarachnoid and general anaesthesia for fractured hip (McKenzie, Wishart and Smith, 1984) is an important contribution to the literature in this area. In their series they demonstrated that the mortality at 14 days was significantly less in the subarachnoid group, but no difference existed at 1 year. They concluded that subarachnoid anaesthesia plays no part in decreasing the burden which this disease places in health care resources.

I believe the authors are selling themselves short. There are many possible causes of death during the year following a fractured hip, from surgery and anaesthesia-related causes in the early perioperative period to causes related to the patient’s often underlying pathology. The authors have shown that they can prevent many of the early deaths. One piece of the jigsaw puzzle has been put into place. The fact that the later deaths could not be prevented should not be an admission of failure. For example, penicillin undoubtedly decreases the mortality of septuagenarians during a bout of pneumococcal pneumonia compared with no antibiotic treatment. However, if it were found that there was no significant effect on mortality at 1 yr, I doubt if we would stop using the drug or conclude that it was of no use in the disease.

In this study the principle of reduction in early mortality is the important issue. This raises other important questions. It holds true also in young, healthy patients with hip fractures or in patients having elective hip surgery (who have better long-term prognosis). Might not this early reduction in mortality indeed confer a long-term benefit?

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REFERENCE

AIRWAY OBSTRUCTION—AN UNUSUAL PRESENTATION

Sir,—Obstruction of endotracheal tubes and their connectors by foreign bodies has been documented extensively. Among the items responsible have been hardened KY jelly (McLellan, 1975), tumour fragments (Barat, Ascorve and Avello, 1976), Blenderm tape (Jago, Johnstone and Restall, 1977) and the plastic sheath from a disposable needle (Wittman, 1982). The blockage has usually become apparent very quickly because of airway obstruction. We wish to report an instance with the unusual presentation of acute hypotension.

A 73-year-old man was anaesthetized for cystoscopy with thiopentone followed by nitrous oxide, oxygen and enflurane breathed spontaneously via a face mask and Bain system. After 30 min the surgeon decided to proceed to retropubic prostatectomy. Atracurium 40 mg i.v. was given and the trachea intubated with a 9-mm cuffed endotracheal tube with a Cobb’s connector. Manual ventilation required high inflation pressures, but both sides of the chest were seen to be moving and air entry was heard on auscultation. Ventilation was continued using a Manley ventilator.

At this point, the systolic arterial pressure was observed to decrease rapidly from 90 to 50 mm Hg and remained low despite the rapid infusion of crystalloid. The Manley began to “hiccup” and, on reverting to manual ventilation, inflation proved impossible. The endotracheal tube was changed immediately, ventilation...