range of 4 to 7 mg/kg." The dose we used in our study was within that range.

Second, in our study, 17.5% had an Apgar score of less than 7 at 1 min, and all were ≥ 7 at 5 min. The results were not worse than those in the article quoted by Kwan, Chen and Liao and showed Apgar scores of 6 or less in 24.7% of neonates [2]. Moreover, in our study, the umbilical venous and arterial blood-gas tensions and acid-base values, which are more indicative of fetal depression than Apgar scores, were normal (e.g., umbilical venous and arterial pH values were 7.3 and 7.29, respectively). We also found no correlation between the neuroadaptive capacity scores, a more refined technique than Apgar scores, and thiopentone dose. We feel that, irrespective of the neuromuscular blocker used, every effort should be made to optimize the intubating conditions as the most common cause of maternal death from anaesthesia is failure to intubate the trachea. If this is provided by increasing the dose of thiopentone from 4 to 6 mg kg⁻¹, so be it.

In respect of textbook recommendations of the dose of thiopentone, we suggest that these should be reconsidered on the basis of our study, especially when a neuromuscular blocker other than suxamethonium is used or difficulty in intubation is encountered.

Sir,—We read with interest the article by Abouleish and colleagues [1]. However, we are unhappy with the conclusion that the combination of thiopentone 6 mg kg⁻¹ and rocuronium 0.6 mg kg⁻¹ is a safe choice for rapid sequence induction for Caesarean section. While 90% of the patients in their study had good to excellent intubating conditions, this represents only one criterion for choosing a neuromuscular blocker for rapid sequence induction.

Failed intubation occurs in at least 1 in 300 obstetric general anaesthetics. In the vast majority of these situations the delivery is not urgent and the mother is allowed to regain consciousness. If immediate delivery is essential, many obstetric anaesthetists advise continuing anaesthesia with face mask ventilation until spontaneous ventilation returns.

Rocuronium 0.6 mg kg⁻¹ has a duration of action of 30 min, which in the event of failed intubation requires continued mask ventilation encouraging gastric distension and a heightened risk of aspiration.

The ideal neuromuscular blocking agent is one with a rapid onset but also a rapid offset, notably suxamethonium.

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Sir,—Abouleish and colleagues [1] described the use of rocuronium (Org 9426) in 40 elective Caesarean section patients at full term without fetal distress. They concluded that its use "was found to be safe for mother and fetus". We believe that this conclusion needs some qualification.

Rocuronium is not the first non-depolarizing neuromuscular blocker to be used for rapid sequence induction of anaesthesia for Caesarean section. Vecuronium in a priming dose regimen [2] has been described as an alternative drug, although the onset time and clinical duration were found to be longer than desired. The authors were careful to state that vecuronium should be considered only when suxamethonium is contraindicated.

Sir,—We absolutely agree with McSwiney, Edwards and Wilkins and Swales and Gaylard that suxamethonium is the drug of choice for Caesarean section. The reasons are not only its short duration of action as they mentioned, but also the provision of ideal intubating conditions and the absence of neonatal effects, rare in the presence of abnormal cholinesterase [1]. Suxamethonium has withstood the test of time. The intention of our study was not to compare rocuronium with suxamethonium, and we did not do that. Our conclusion was not to advocate replacing suxamethonium by rocuronium, and we did not state that. However, as mentioned in the introduction of our article, the use of suxamethonium may be inadvisable in certain conditions, for example susceptibility to malignant hyperthermia, abnormal cholinesterase genotypes and susceptibility to hyperkalaemia. Under these conditions, other neuromuscular blockers should be considered. Of those available, the one with the shortest onset of action is rocuronium, thus ensuring control of the airway in the minimum time following loss of consciousness.

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