Second, in this study, the endoscopy at the isthmus of the fauces showed that the narrowed oral airway space abruptly and significantly dilated during oscillatory movements of the soft palate and the tongue base (pharyngeal fasciculation) after succinylcholine administration. Thus, the FMV improvement after succinylcholine administration is contributed to reopening of the pharyngeal airway by the pharyngeal muscle contraction. However, other than the soft tissue airway at the pharynx, the laryngeal aperture is another important site that may significantly affect gas flow of the upper airway.\(^2,5\) It has been shown that the vocal cord closure is a primary source of difficult or impossible FMV during anesthesia induction with sufentanil.\(^2,5\) After anesthesia induction, it is also possible for the epiglottis to overlie and obstruct the laryngeal aperture or to seal against the posterior pharyngeal wall, especially when the patients are placed in a neutral head and mandible position without any airway intervention.\(^3\) Because the authors did not observe changes of both position of the epiglottis in the pharynx and configuration of the laryngeal aperture during succinylcholine-induced upper airway muscle fasciculation, contribution of these factors to the FMV improvement by succinylcholine cannot be excluded.

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Furthermore, I strongly disagree with the editorialists’ opinion that administration of succinylcholine instead of a nondepolarizing agent reliably preserves the option to “wake the patient up” if needed. After the administration of succinylcholine 1 mg/kg, it took as long as 10.5 s and 11.2 min for the recovery of the first train-of-four twitch (T1) to 10%, and as long as 8.5 min from tracheal intubation to the return of spontaneous respiration.9 These findings reemphasize that after succinylcholine-induced apnea, “achievement of functional recovery before significant desaturation is not a realistic possibility”.10

It is a potentially dangerous misconception to consider the administration of a muscle relaxant to be the Rubicon. Rather, the Rubicon is the administration of a hypnotic at a dose that abolishes spontaneous respiration. The chances of successfully restoring adequate spontaneous respiration before severe hypoxemia develops in the presence of difficult or impossible FMV in an anesthetized, apneic patient whose is prone to airway collapse because of reduced pharyngeal muscle tone are very small. Thus, once we have crossed that Rubicon, our goal must not be to “consider preserving a way back over the bridge” (i.e., awaken the patient), but to provide as quickly as possible optimal conditions not only for FMV but also for endotracheal intubation or insertion of a supraglottic airway device. If patients with obvious indications for primary awake fiberoptic intubation are excluded, early relaxation will not worsen the quality of FMV,5,5 often improves it,5,5 and provides superior intubating conditions. These are no longer the 1960s or 1970s when effective airway devices were rare or nonexistent and “preserving a way back over the bridge” was clearly a safety issue. Today, fiberscopes, video laryngoscopes, and numerous supraglottic airway devices are readily available. It has become an extremely rare event that effective oxygenation and securing the airway cannot be achieved by any of these devices in the fully relaxed patient. However, for obvious reasons similar effectiveness of these devices cannot be expected in nonparalyzed patients. Even the sternest proponents of the “no muscle relaxant before effective FMV” rule do not most likely to administer a muscle relaxant when hypoxemia develops during failed FMV,11 and they do not hesitate at all to administer a muscle relaxant during rapid sequence induction. If ensuring effective FMV before injection of the muscle relaxant were that essential for patient safety, awake fiberoptic endotracheal intubation would have to be performed in all patients undergoing rapid sequence induction.

Considerable reservations about the rationale and safety of the practice of having to demonstrate effective FMV before administering muscle relaxants have previously been voiced.12,13 Numerous findings3–7 support the view that in airway management muscle relaxants are much more often the solution than the problem;14; that the earliest possible administration of the muscle relaxant may well be the most effective tactic in routine clinical practice; and that the practice of insisting on effective FMV before administering a muscle relaxant should be abandoned.12–14 I know of numerous academic and nonacademic anesthesia departments who have completely done so, including our own department at a tertiary university referral center with 110 anesthesiologists. Personally, I have done so since 25 yr ago.

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