CORRESPONDENCE


(Accepted for publication October 10, 1985.)

In reply.—We appreciate the interest Dr. Jantzen and his colleagues have shown in our report and in the relation between neuromuscular blocking agents and intraocular pressure (IOP) changes. Unfortunately, they seem to have missed our main point, which is that succinylcholine should not be avoided in open eye injuries solely because of the possibility of a mild elevation in IOP when more vital factors must be considered. For example, a full stomach may dictate the need for rapid intubation to prevent aspiration. Coughing or staining must be avoided during intubation to prevent an even greater rise in IOP than that produced by succinylcholine.

As Dr. Jantzen points out, succinylcholine raises the IOP in the intact eye. However, there is doubt that it increases pressure under deep anesthesia. His references are Murphy, who nowhere in his article makes this statement, and fig 1, which is apparently a single experiment in a dog under fentanyl anesthesia. If Dr. Jantzen intends to cite Cook’s work as the basis for this statement, those patients were given less than 1 MAC halothane, hardly deep anesthesia. Furthermore, it has not been proved, and we think it doubtful, that the same mechanisms operate in the injured eye. We thank Dr. Jantzen for calling attention to our error in citation about alcuronium in place of atracurium.

Finally, we concur with the conclusion of the recent review article cited by Dr. Jantzen, “There is, as yet, no ultrarapidly acting nondepolarizing neuromuscular blocking agent to allow succinylcholine to be abandoned completely and no method of succinylcholine pretreatment is completely effective. For such surgery the anesthesiologist must balance the overall risk to the patient with the risk to the injured eye, in deciding if succinylcholine is to be used.”¹

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REFERENCE


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Succinylcholine and Open Eye Injury. II.

To The Editor:—I wish to commend Libonati et al.¹ for their recent clinical report documenting the safe use of succinylcholine in open eye surgery. My experience here at the Massachusetts Eye and Ear Infirmary is similar to the data presented for the Wills Eye Hospital.

Pretreatment with a nondepolarizing muscle relaxant, use of intravenous lidocaine, and assurance of adequate depth of anesthesia prior to intubation have allowed the use of succinylcholine for full-stomach—open-eye situations without causing further eye damage. The Massachusetts Eye and Ear Infirmary treats several hundred open eye injuries each year, and the majority are intubated as de-