In reply:—I believe that the practice of pretreatment before succinylcholine with depolarizing or nondepolarizing agents should be reviewed. The clinical application of any pretreatment technique depends not only on its ability to prevent muscle fasciculations, but also on its ability to diminish the associated side effects, such as myalgia, increased intragastric pressure, serious increases in serum potassium, etc. Our report simply describes the phenomenon of self-taming as a technique that diminishes succinylcholine-induced fasciculations. Its possible protection against other side effects of succinylcholine needs further investigation. In contrast to taming with nondepolarizing drugs, self-taming does not delay the onset or diminish the block of a subsequent full dose of succinylcholine. Incomplete succinylcholine block may follow pretreatment with nondepolarizing muscle relaxants, thereby making endotracheal intubation more difficult and hazardous in the patient with a full stomach. None of our patients showed significant bradycardia following the full dose of succinylcholine injected 45–60 sec after the taming dose. This would be expected in view of the findings of Mathias and Evans-Prosser, who showed that a 5-minute interval between the first and second doses of succinylcholine is optimum for producing bradycardia.  

Anis Baraka, M.D.  
Professor and Chairman  
Department of Anesthesiology  
American University of Beirut  
Beirut, Lebanon

REFERENCE


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Survey of the Use of Flammable Anesthetics

To the Editor:—The continued use of flammable anesthetic agents is a controversial issue. The extent to which these agents are employed in anesthesiology training programs will have a significant effect on their future role in the practice of anesthesiology. This was recognized by the current members of the American Society of Anesthesiologists Committee on Flammable Hazards and Electrical Equipment. Accordingly, the committee attempted to determine the current status of flammable anesthetic agents by means of a questionnaire that was mailed to 202 directors of anesthesiology residency training programs. One hundred and seventeen questionnaires were returned.

Eighty-one of the respondents had not used any flammable agents in 1976. Table 1 shows the years in which flammable anesthetics were discontinued by non-user respondents. The major reasons for discontinuing the use of flammable anesthetics were the risks of a fire or explosion; expense to maintain an explosion-proof environment; the widespread use of the electrosurgical unit; and the belief that the flammable agents have no pharmacologic advantage over nonflammable drugs currently available.

Of the 37 respondents who used flammable anesthetic agents in 1976, 29 used diethyl ether and 34 used cyclopropane. These programs averaged 13,449 anesthetics/institution, of which 395 anesthetics/institution were with flammable anesthetic agents. The range was 0.3 to 8 per cent of the anesthetics being flammable. Six of the 37 users have now discontinued the use of flammable agents. Their reasons for doing so are similar to those for the non-users.

It is evident from this survey that a declining