Correspondence

Complications of Ketamine

To the Editor:—After a year's experience with ketamine hydrochloride, it seems timely, for the purpose of documentation, to add our department to what is probably a growing group of dissenters to the original claims made for the drug. For ease of administration and analgesic properties, there is no question of its excellence. We can now document, however, a number of complications from which ketamine hydrochloride was claimed to be free.

In the approximate order of their occurrence, we have encountered severe laryngospasm and respiratory arrest in neonates. Hypoxic cardiac arrest secondary to respiratory depression has been observed in a debilitated adult. Severe airway obstruction has occurred in a child under ketamine anesthesia and, most recently, vomiting with aspiration occurred in an infant with a full stomach. In addition, we have observed a hysterical postanesthetic reaction in a child following ketamine. We have noted increased tolerance to its effects in alcoholics and in a number of patients who received several ketamine anesthetics.

Our current recommendation would be that the candidate for ketamine anesthesia be as carefully selected and prepared as any other patient for general anesthesia.

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State of Contracture in Malignant Hyperthermia

To the Editor:—The case report, “Malignant Hyperthermia Associated with Hypocalcemia,” by Pollock and Watson (Anesthesiology 34: 188, 1971) presented an excellent theoretical discussion of the roles of the cyclic AMP system and psychotropic drugs in producing hyperthermia, but did not mention the possible role of succinylcholine in initiating the chain of events. Their patient was probably in a state of muscle contracture after incomplete relaxation with succinylcholine. The term “contracture” signifies mechanical shortening of muscle maintained without muscle action potential and independent of transmission at the neuromuscular junction.

The prolonged relaxation phase that some patients have in the contraction–relaxation cycle of striated muscle deserves mention in any discussion of the etiology of malignant hyperthermia. Some patients with slow relaxation develop progressive muscle stiffness with exercise, leading to a state of contracture.1 There are metabolic diseases with specific enzyme defects, such as McArdle’s disease (muscle phosphorylase deficiency)2 and phosphofructokinase deficiency,2 in which exercise-induced contractures occur. According to current concepts, in order for a skeletal muscle to relax, the sarcoplasmic reticulum must actively re-accumulate calcium ions from the aqueous sarcoplasm, thereby depriving the myofibrils of the calcium necessary for contraction.4,5 It takes energy in the form of ATP and enzymatic activity to relax a contracted muscle—it is not a passive process. The term “relaxing factor” is used to refer to the ability of the sarcoplasmic reticulum to accumulate calcium. The activity of relaxing factor can be measured, and a patient with a normal contraction phase but a slow relaxation phase and