ccns to the anesthesia medical director. The assigned anesthesia team, on the day of surgery, evaluates and reconfirms their patient’s status in the anesthesia holding area before entering the operating room. This establishes a personal rapport with the anesthesiologist who will be directly responsible for the patient’s management.

Lee and Hillman report a preanesthesia clinic service in Australia with comparable and contrasting development from Stanford’s APEC. The conceptual goals appear similar: to provide efficient quality services, increase productivity, and decrease cost. I agree that further studies are needed to define the APEC’s role in patient-care outcomes.

Silverman discusses the expanding role of the anesthesiologist in today’s practice and the increased visibility the APEC can provide. I concur with Silverman that, to expand our specialty into the future, anesthesiology must evolve beyond the traditional operating room/procedure role.

Recently at Stanford, the Department of Medicine proposed structuring a preoperative screening clinic staffed by an internist, pulmonologist, and cardiologist for evaluation of presurgical patients. The surgical leadership responded in a concise and congruent manner. They indicated that the anesthesiologists at Stanford are the primary preoperative and operating room medicine experts and that their patients would continue to attend the APEC for presurgical assessment.

Positive changes can occur and certain advantages can accrue to the anesthesiologist and department of anesthesia when an APEC is established.

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Interaction between Nondepolarizing Muscle Relaxants

To the Editor—In a recent article, Erkola et al.1 demonstrated that a shorter-acting muscle relaxant (mivacurium), if administered after a longer-acting muscle relaxant (pancuronium), takes on the characteristics of the first drug. Unfortunately, the authors did not take the opportunity to study a cross-over group (i.e., a group to whom pancuronium was given after mivacurium). Had they done so, it is highly likely that they would have observed the phenomenon reported by Feldman et al. in 1993.2 In this study in the isolated forearm, the authors observed that the administration of pancuronium after 50% recovery from a vecuronium-induced block led to a reduction in pancuronium recovery index. Therefore, the recovery from the effects of one nondepolarizing muscle relaxant given after partial recovery from another more resembles the recovery from the muscle relaxant given first.

Had Erkola et al. been aware of this previously published work, it is unlikely they would have suggested that pancuronium’s capacity to inhibit pseudocholinesterase may be responsible for the prolongation of the effect of mivacurium or that the effect they observed was due to the long β half-life of pancuronium. A more tempting hypothesis is put forward by Feldman et al.2 (i.e., that the second drug displaces some of the first drug that remains in the biophase onto the acetylcholine receptors and that, therefore, much of the block elicited by the second drug is actually effected by the proportion of the first drug, which remains in the biophase). The recovery, therefore, resembles that of the first drug.

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