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citalopram in anaesthetized man

Sir,—I read with great interest the paper by Drs Payne and Hughes (1981) on the evaluation of atracurium in anaesthetized man. The rapid onset and relatively short duration of action and the absence of circulatory side-effects of atracurium are equally impressive. I am concerned, however, about the method of administration of atropine and neostigmine used for the antagonism of the residual atracurium block. It appears from figure 3 of their paper that atropine 1.2 mg had been administered 2–3 min before the injection of neostigmine. It has been reported (Rosner, Kepes and Foldes, 1971) that, when atropine 12 μg kg⁻¹ (0.84 mg per 70 kg⁻¹) was injected i.v., the mean heart rate in a group of 10 patients increased from 72.2 ± 3.5 (SEM) to 101.2 ± 49 in 2 min. When the same dose of atropine was injected with neostigmine 40 μg kg⁻¹ (2.8 mg per 70 kg⁻¹), up until 3 min, there was a moderate increase of the mean heart rate followed by moderate bradycardia. This sequence of events results from the fact that atropine reaches muscarinic receptor sites in the heart more rapidly than does neostigmine. What were the heart rates of the patients just before and 2 min after the i.v. injection of atropine 1.2 mg kg⁻¹? One of the main advantages attributed to atracurium over other neuromuscular blocking agents in clinical use is that it does not increase the heart rate during induction of anaesthesia. We have made no such claim; we merely drew attention to the cardiovascular stability after injection of the drug as evidence that it did not release histamine (Payne and Hughes, 1981). Furthermore, we do not regard a heart rate of less than 80 beat min⁻¹ at the end of anaesthesia as evidence of tachycardia; but even if it were so, it scarcely justifies an alteration in our practice.

Finally, we believe that when a short-acting neuromuscular blocking agent such as atracurium is used judiciously there should be no need to antagonize its action with neostigmine, which carries its own risks (Payne, Hughes and Al-Azawi, 1980).

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LEAK FROM AN OXYGEN FLOWMETER

Sir,—The report of Powell (1981) is yet another example of the reduction in delivered oxygen percentage to be expected from an oxygen flowmeter on the left-hand side of a flowmeter manifold when a leak occurs anywhere in the manifold. Eger and colleagues (1964) first drew attention to the importance of locating the oxygen flowmeter on the right next to the flowmeter

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