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An unusual reaction to precurarization

To the Editor:

We recently witnessed an unusual reaction to “precurarization”. An ASA I, 40-yr-old Caucasian female presented for varicose vein surgery. Her medical history included tonsillectomy, migraine headaches and allergies to penicillin and tape.

No premedication was ordered. Midazolam 1 mg was administered *iv* on arrival outside the operating room. In the operating room, standard monitors and an automatic BP cuff were placed. Her BP was 110/72 mmHg and HR $118 \cdot \text{min}^{-1}$. Oxygen was applied by mask and d-tubocurarine 3 mg was administered *iv*. At this time the patient complained of “tingling and pins and needles” on the scalp and raised her hands to hold her head. Erythematous wheals were evident on the arm proximal to the *iv* site. Vital signs were unchanged and the patient was reassured. Within seconds she became very distressed, grabbed her head and complained of pain like “pins and needles” in her head. Her entire skin became bright red and warm. The BP was 128/83 mmHg and HR $115 \cdot \text{min}^{-1}$. The patient was severely distressed and remained conscious with no obvious neurological deficits.

Because of the patient’s discomfort but haemodynamic stability, she was anaesthetized with thiopentone and tracheal intubation was facilitated with succinylcholine. Anaesthesia was maintained with $\text{N}_2\text{O}:\text{O}_2$ (70:30) and isoflurane. Blood pressure, heart rate and oxygen saturation remained stable throughout the period of the reaction and anaesthesia. Within five minutes of induction, the cutaneous vasodilatation had resolved completely. There was no evidence of bronchospasm, oedema or urticaria. Surgery proceeded uneventfully and recovery from anaesthesia was normal. In the recovery room she was pain free, had no neurological deficit, headache or rash, but complained of being cold.

Unfortunately the patient was not followed up with allergy testing, as recommended by Watkins.¹ We can offer no completely satisfactory explanation for this reaction but suggest that the history of migraine may have played a role. Acute cerebral vasodilatation due to histamine release may possibly be a basis for certain migraine headaches and this might suggest a mechanism for the reaction observed following *iv* d-tubocurarine.^{2,3} In our patient, there were signs of histamine release such as cutaneous erythema but no hypotension.

No similar case could be found in the literature.

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The TURP syndrome

To the Editor:

We read with interest Dr. Jensens’s article on TURP syndrome.¹ Her guidelines regarding “prevention of TURP syndrome” contain some disputed areas.

(1) She advocated restricting the duration of resection to one hour although Melchoir *et al.*, after an analysis of 2223 consecutive TURP operations, concluded that absorption is time-related only in resections which exceeded 150 min.²

(2) With regard to limiting the hydrostatic pressure of the irrigating fluid to 70 cm of water, we wish to point out that there are two pressures in action in the operating field: the dynamic pressure of the jet and the static pressure exerted by the contents of the urinary bladder and the weight of the tissues resting on the bladder (intestines, abdominal wall etc.). Most of the driving head of pressure is lost as a result of friction and lateral losses against the tubing and the valve of the resectoscope and what is left is the final dynamic pressure in the jet. Hultén, using an engineering model of the human bladder,