with extracorporeal circulation, in patients with already damaged myocardium, evokes an excessive influx of calcium through the altered sarcolemma and may irreversibly damage the myocardial cells, even in the presence of a calcium-mobilizing drug, 4-aminopyridine.

Calcium is an important regulator in biological cell processes, especially in muscle cells. But even though 4-AP is a positive inotropic drug, it may not act to modify the altered excitation-contraction coupling process.

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PREMEDICATION FOR PAEDIATRIC DAY-CARE SURGERY

DEAR SIR,

The excellent paper by Desjardins, Ansara and Charest on premedication for paediatric day-care surgery[1] confirms the practice and opinion of many paediatric anaesthetists. The use of premedication will usually confer little benefit on the child and will occasionally produce unwanted results, delaying the return of normal sensations and behaviour. Yet premedication remains a "routine" in many practices, often given by injection, thereby causing unnecessary pain and distress.

The statement that the presence of a parent during induction of anaesthesia, "is difficult and of no great value" must not go unchallenged, however. Using Vernon's method of assessment[2] we demonstrated a highly significant improvement in both global mood during induction and post-hospitalization behaviour when the mother was present during induction of anaesthesia in children undergoing outpatient surgery.[3] We also demonstrated a close correlation between the degree of disturbed behaviour at induction and behaviour after return home, which Desjardins, Ansara and Charest were unable to detect. Children who became disturbed during induction of anaesthesia showed signs of psychological disturbance afterwards; the greater the upset, the greater the effect. We consequently routinely invited and advised the mother's presence at induction in all our subsequent practice, which has so far not produced any difficulties.

The omission of premedication may not be the final word in preoperative preparation. We believe that the psychological preparation of both mother and child at a short interview when surgery is first advised is beneficial, as is the provision of an anaesthetic room, especially one equipped for the entertainment of an alert active child.[4] But the single most effective improvement in acceptance of induction came with the adoption of concealed painless intravenous induction, using an intradermal spray of local anaesthetic or five second spray of ethyl chloride before a concealed injection.[5]

Finally, many intravenous injection agents are unsuitable for children because of pain on injection. We render methohexitone painless by adding a drop of lignocaine before injection.[4]

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DEFECTIVE TRACHEAL TUBE CONNECTOR

DEAR SIR,

I would like to draw to the attention of your readers the potential dangers of a recent problem encountered in the use of a DUPACO aluminum tracheal tube connector.