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Fear of Operating Room 8

To the Editor:—Recently, a patient in our institution manifested anxiety concerning impending operation and anesthesia, which in part was related to the reading of a current novel. Following an explanation of anesthetic risks during preanesthetic evaluation, the patient, a 42-year-old woman who had a mass in the breast, asked in what room her operation would be, adding, "I hope it won't be number 8." She referred to the many "unexplained" anesthetic deaths that occurred in the notorious room 8 at the fictitious Boston Memorial Hospital in the popular novel *Coma*. The patient was considerably reassured by further informative discussion. By coincidence, her operation had indeed been scheduled for operating room 8. We hope that this episode, which is the first of its kind that has come to our attention, does not herald a mass rejection of the number 8 and send it into an ignominious exile from the operating suite with the supposedly fateful room 13.

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REFERENCE

1. Cook R: Coma, New York, Signet, 1977

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Local Anesthesia for Laparoscopy in a Case of Myotonia Dystrophica

To the Editor:—In an interesting report,[1] Mitchell *et al.* described the use of general anesthesia in three patients with myotonia dystrophica. One patient underwent laparoscopic tubal ligation. In addition to nicely demonstrating an abnormal response to succinylcholine, the authors described the dangers of general anesthesia in myotonic patients. Our experience indicates that laparoscopic tubal ligation can be safely achieved in such patients with use of local infiltration anesthesia.

REPORT OF A CASE

A 29-year-old woman who had myotonia dystrophica was admitted for elective laparoscopy and tubal ligation. There was a history of atrial flutter, treated with oral digoxin, 0.25 mg, daily. Physical findings included myotonia, wasting of facial musculature, distal-extremity weakness, and a high-arched palate. Electrocardiography showed atrial flutter with varying atrioventricular block (2:1 to 7:1) and a ventricular rate of 50–95 beats/min. A digoxin level was within the therapeutic range, but serum potassium was 5.5 mEq/l. Vital capacity was 3,600 ml. Other laboratory results were normal.

Following intravenous injection of fentanyl, 75 μg, given in 25-μg increments, the skin, fascia and peritoneum were anesthetized by infiltration of bupivacaine, 10 ml, 0.5 per cent. After inflation of the peritoneal cavity with nitrous oxide, 2 l, through a Verres needle, a Wolf laparoscope was introduced via a laparoscopic trochar. Bupivacaine, 5 ml, 0.5 per cent, was dripped on each fallopian tube to provide analgesia for subsequent cauterization. During the 35-min procedure vital signs were unchanged, and the patient complained of only slight discomfort. She was discharged on the first postoperative day.

As described by Mitchell *et al.*,[1] patients who have myotonia are predisposed to apnea in response to thiopental, narcotics, diazepam, and halothane, while succinylcholine causes muscle contractures. As a result, both intraoperative and postanesthetic respiratory difficulty may occur. The pitfalls of general anesthesia for laparoscopy in patients with myotonia can be avoided by local infiltration anesthesia. We feel that when feasible, patients with myotonic disorders are best managed with local or conduction anesthetic techniques.

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REFERENCE

1. Mitchell MM, Hassan HA, Savarese JJ: Myotonia and neuromuscular blocking agents. ANESTHESIOLOGY 49:44–48, 1978

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