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"Self-taming" with Succinylcholine and Muscle Pain

To the Editor:—"Self-taming" succinylcholine doses have been reported to reduce fasciculations[1] but not the incidence of succinylcholine-induced myalgia.[2,3]

I studied 50 patients, 20 to 40 years old, ASA class I, undergoing tubal ligation under identical conditions. They were divided into two groups of 25 each as follows: to Group 1, a bolus dose of 100 mg succinylcholine was given; to Group II, a pretreatment dose of 10 mg followed by a bolus dose of 100 mg succinylcholine was given. All patients were ambulatory within 6 to 8 h. Anesthesia was induced in all patients with 250 mg sodium thiopental followed by succinylcholine. Anesthesia was maintained with nitrous oxide and oxygen (70:30%).

Postoperatively, assessment of muscle pain was done by a physician, who was unaware of the drug sequence, using the gradation described by Churchill-Davidson.[4] The results (table 1) are contradictory to the previous reports[2,3] since none of the patients in Group 2 had pain.

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TABLE 1. Incidence of Succinylcholine-induced Myalgia (N = 25 each)

	Patients without Pain	Patients with Pain	Severity		
			Mild	Moderate	Severe
Group 1	7 (28%)	18 (72%)	7	9	2
Group 2	25 (100%)	—	—	—	—

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Predicting Painful Venipunctures

To the Editor:—Recently, Halden and Uppfeldt[1] have reported the usefulness of a topical anesthetic, a lidocaine-prilocaine cream, in reducing the pain experienced by children when a venipuncture is performed to introduce an iv catheter (ivc). The procedure, however, is time-consuming and requires a dressing. Other clinicians have advocated reassurance or local subcutaneous anesthetic agents which also are time-consuming. It would be helpful to the clinician to be able to identify which patients are at risk for a particularly painful experience so that one of these interventions can be taken. Similarly, it would be useful to the researcher to be able to identify prospectively a specific population sample. Previous work[2] has shown prior memory of dental injection pain can be useful in predicting present experienced pain. We have used a similar method, with adults, for venipuncture pain (ivc).

Twenty-three patients (10 men, 13 women, median age 42.6 years) were seen on a hospital ward as they became available. Only those who were English-speaking and had a clear sensorium were chosen. Consent was obtained in all cases. The patients were asked to report on a scale of 0–100 (where 0 was no pain and 100 was intolerable pain) their past average venipuncture (ivc) pain. All of the patients had had prior experiences. An experienced iv therapist then introduced, with a minimum of reassurance, an iv catheter (22- through 18-gauge) into the forearm. The patient then was asked to report the pain he experienced.

Median values for past and present pain were 25 and 10, respectively. The product-moment correlation between the two was $r = 0.86$, $P < 0.00001$. Four patients reported moderate to severe memories, while only two of them actually experienced moderate to severe pain (>50) (see table 1).

The correlation is high enough to be of use clinically in predicting which patients would definitely require

TABLE 1. Grouped Frequency Distribution of Scores on Pain Scale

	0–25	26–50	51–75	76–100
Past memory	12	7	1	3
Present experience	19	2	1	1