

FIG. 1. The high pressure uterine dispacer. The arrow indicates attachment of the jet ventilator to the inflatable bag.

University of California, San Diego San Diego, California 92103

REFERENCES

- Redick LF: An inflatable wedge for prevention of aortocaval compression during pregnancy. Am J Obstet Gynecol 133:458– 459, 1979
- Millar WL: Management of a difficult airway in obstetrics. ANES-THESIOLOGY 52:523-524, 1980
- Thomas TC, Zornow MH, Scheller MS, Unger RJ: The efficacy
 of three different modes of percutaneous trans-tracheal ventilation in hypoxic, hypercarbic swine. Can J Anaesth 35:S61
 S63, 1988
- Endler GC, Donath RW: Inflation device to prevent aortocaval compression during pregnancy. Anesth Analg 64:1015-1016, 1985

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Calculating the Potency of Mivacurium

To the Editor:—I am confused by some of the results reported by Savarese et al. in their recent paper on the pharmacology of mivacurium. Specifically, using the data supplied in table 1, I cannot reproduce the ED₉₅ value of 0.081 mg/kg that they calculate. If one performs a log dose-probit transformation and linear regression analysis on only the first four groups (0.03–0.10 mg/kg), the resulting ED₅₀ and ED₉₅ values are 0.052 and 0.10 mg/kg, respectively (table 1). In fact, this estimate of potency is substantiated by the group of patients receiving 0.10 mg/kg that showed 95.7% twitch depression. If the ED₉₅ was, in reality, 0.081 mg/kg, then a dose of 0.10 mg/kg should produce greater than 99% twitch depression; this was not the case.

The authors do not actually state in their paper which groups were employed in calculating the ED_{50} and ED_{95} values. However, since 100% twitch suppression cannot be plotted on a log-probit graph, it appears that only the first four groups (n = 36) could have been used. It would be helpful if the authors could explain in greater detail how they estimated drug potency.

AARON F. KOPMAN, M.D.

Department of Anesthesiology

Long Island Jewish Medical Center

New Hyde Park, New York 11042

TABLE 1. Log-probit Transformation of Data from Table 1 of Savarese et al. 1

Dose (mg/kg)	% Effect	Log-dose	Probit
0.03	9.4	-1.5228	-1.3106
0.05	43.7	-1.3010	-0.1637
0.07	75.3	-1.1549	0.6280
0.10	95.7	-1.0000	1.6955

Equation for the dose-response relationship as determined by linear regression (least squares) analysis of the above log-probit data: y = 5.8598x + 7.513, r = 0.998.

REFERENCE

 Savarese JJ, Ali HH, Basta SJ, Embree PB, Scott RPF, Sunder N, Weakly JN, Wastila WB, El-Sayad HA: The clinical neuromuscular pharmacology of mivacurium chloride (BW B1090U): A short-acting nondepolarizing ester neuromuscular blocking drug. ANESTHESIOLOGY 68:723-732, 1988

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In Reply:—We appreciate the comments offered by Dr. Kopman. His letter reflects the need for a solution to a debatable question: How does one handle 100% or 0% twitch inhibition during construction of a dose-response curve for a neuromuscular blocking drug?

In our publication on mivacurium, we estimated potency of mivacurium during nitrous oxide-narcotic-barbiturate anesthesia using single-twitch stimulation of the ulnar nerve to evoke thumb adduction at

0.15 Hz. This stimulus parameter was used so that the characteristics of mivacurium block might be easily compared with past literature on other relaxants. The methodology is fairly extensively presented and debated in Donlon et al.² where both single-bolus and cumulative doseresponse curves for pancuronium were constructed.

Although we calculated an ED₉₅ of 0.081 mg/kg in our paper, when we administered 0.10 mg/kg to nine consecutive patients, we observed