

CORRESPONDENCE

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More on Succinylcholine and Trismus in Children

To the Editor:—Our recent letter to the editor covered some issues about the use of succinylcholine that we felt were important to discuss.¹ Dr. Rosenberg's reply certainly points out some of the differences in opinion that exist in this area of controversy.² However, we feel obliged to clarify one mistaken impression that Dr. Rosenberg has about the route of administration of succinylcholine in Charlottesville. The intramuscular route of administration of succinylcholine is used in less than 2% of our patients. Therefore, this explanation for the lower incidence of masseter spasm is not substantiated. It is our feeling that part of the explanation for the lower incidence of masseter spasm is the larger dose of succinylcholine that is given. We use 2 mg/kg intravenously in infants and children.

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Use of the Cell Saver in Patients with Sick Cell Trait

To the Editor:—The cell saver is commonly used today for many different types of operations, including hepatic transplantation.¹ Use in patients with sickle cell trait has been advocated;² however, the potential to induce sickling in the salvaged blood is a cause for concern.

A 22-yr-old black female with sickle cell trait underwent hepatic transplantation for end stage liver disease secondary to chronic non-A, non-B hepatitis. A Haemonetics Cell Saver III, operated in the manual mode (20% longer wash cycle than automatic mode to enhance heparin removal), was used to salvage blood during the transplant. Approximately 300 ml of blood was collected in the cell saver reservoir, at which time samples from the patient and the reservoir were sent for sickle cell smear. The blood in the reservoir was then immediately processed by the cell saver. A sample of the processed blood was also sent for a sickle cell smear. Samples from the patient and the reservoir revealed no evidence of sickling. However, the processed blood revealed a 50% incidence of sickling and therefore was not reinfused to the patient. The case proceeded uneventfully, and there were no post-operative complications. There was no evidence of sickling on any subsequent smears done on blood obtained from the patient and she was discharged from the hospital 18 days later.

Black and Dearing² reported using a Haemonetics Cell Saver in a patient with sickle cell trait undergoing cardiopulmonary bypass, without apparent complications. They did not perform a microscopic examination of the processed blood prior to reinfusion of the red cells; however, an examination of the patient's blood at 24 h showed no evidence of sickling.

Blood samples drawn from our patient and the reservoir (immediately prior to processing) had no indication of sickling, but the blood drawn immediately after processing was severely affected. Therefore, sickling could be attributed to the cell saver washing process.

A recent communication from Romanoff *et al.*³ suggested that blood from patients with sickle cell trait could be stored in acid-citrate-dextrose (ACD) and citrate-phosphate-dextrose (CPD) and reinfused without untoward sequelae, with the exception of its use in exchange transfusions in neonates. Although this could be true for whole blood, there

are no data to suggest that cell saver packed red cells may not exhibit sickling during storage.

In view of the massive amount of sickling seen in the processed blood from this patient, the efficacy of using the cell saver for patients with sickle cell trait must be questioned.

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