

Miller Neuromuscular Blockers

N-M Blocking Agents

cisatracurium

intermediate duration

onset to intubation=2 min

clin. duration=30-60 min

95% twitch ht (recovery)=45-90 min

Hofmann elimination---laudanosine

(NB vecuronium/rocuronium are rapidly metabolised because of dual renal/liver metabolism)

-cis,cis configuration is one of 10 stereoisomers of atracurium. approx. 15% of total.

-is 4 X as potent as atracurium.

-minimal cvs effects

-no histamine release (cf. atracurium)+similar to vecur.

-slope of recovery is unaffected by dosage or duration

(no hydrolysis by non specific esterases).

cisatracurium dosage:

intubation 0.15-0.2mg/kg

ED95 (N2O/O2) 0.05 mg/kg

suppl. dose 0.02 mg/kg

dose for relaxation

N2O/O2=0.05mg/kg

volatile=0.04mg/kg

(volatile potentiates by 20-40%)

cont. infusion = 1-2 mcg/kg/min

(used with N2O and IV agents)

Mivacurium

-hydrolysed by plasma cholinesterases at 70-80% rate of sux

-duration 1/2-1/3rd of intermediate duration blockers

-2-3X duration of sux

-block antagonised by anticholinesterase

NB

-neostigmine inhibits acetylcholinesterase

2 major cholinesterases:

1) acetylcholinesterase= 'tissue cholinesterase'

2)butylcholinesterase='plasma cholinesterase or pseudocholinesterase'

-acetylcholinesterase-more important in terms of ACh function at synapse.

-butylcholinesterase-more important for destruction of some cholinergic drugs

(cholinesterases used as nerve gases and insecticides)

Mivacurium

Dosage (mg/kg) Clinical Duration (min)

ED95 0.07-0.08

Intubation (at t = +2.0-3.0 min) 0.2-0.25 15-20

Relaxation (N2O/O2) 0.1 10-15

Relaxation (Vapor) 0.08 10-15

Maintenance 0.05-0.1 5-10

Infusion 3-15 (average 6) ?g/kg/min

Pancuronium

Dosage (mg/kg) Clinical Duration (min)

ED95 0.06-0.07

Intubation (at t = + 2-3 min) 0.08-0.12 60-120

Relaxation (N2O/O2) 0.05-0.06 30-60

Relaxation (Vapor)	0.03	30-60
Maintenance	0.01-0.015	30-40

Pipecuronium

Dosage (mg/kg)	Clinical Duration (min)	
ED95	0.04-0.05	
Intubation (at t = + 2–3 min)	0.08-0.12	80-120
Relaxation (N2O/O2)	0.04-0.06	40-60
Relaxation (Vapor)	0.2-0.3	40-60
Maintenance	0.005-0.01	30-45

Vecuronium

Dosage (mg/kg)	Clinical Duration (min)	
ED95	0.5	
Intubation (at t = + 1.5–3 min)	0.1-0.2	45-90
Relaxation (N2O/O2)	0.05	25-40
Relaxation (Vapor)	0.03-0.04	25-40
Maintenance	0.01-0.02	15-30
Infusion	0.8-2.0 ?g/kg/min	

Rocuronium

Dosage (mg/kg)	Clinical Duration (min)	
ED95	0.3-0.4	
Intubation (at t = +60–90 s)	0.6-1.0	35-75
Relaxation (N2O/O2)	0.3-0.4	30-40
Relaxation (Vapor)	0.2-0.3	30-40
Maintenance	0.1-0.15	15-25
Infusion	8-12 ?g/kg/min	

Atracurium

Dosage (mg/kg)	Clinical Duration (min)	
ED95	0.23	
Intubation (at t = +2–3 min)	0.5-0.6	30-45
Relaxation (N2O/O2)	0.3-0.4	30-45
Relaxation (Vapor)	0.2-0.3	30-45
Maintenance	0.1-0.15	15-20
Infusion	4-12?g/kg/min	

Cis-atracurium

Dosage (mg/kg)	Clinical Duration (min)	
ED95	0.05	
Intubation (at t = +1.5–3 min)	0.15-0.2	40-75
Relaxation (N2O/O2)	0.05	30-45
Relaxation (Vapor)	0.03-0.04	30-45
Maintenance	0.01-0.02	15-20
Infusion	1-2 ?g/kg/min	

Peripheral Nerve Stimulation

Stimulating a peripheral nerve (usually the ulnar nerve at the wrist or elbow) and visually observing contraction of the fingers (adductor pollicis and flexor digitorum muscles) is the most commonly advocated method of monitoring neuromuscular function clinically. This stimulation need not be restricted to the arm; any superficially located neuromuscular unit may be monitored. Stimulating the facial nerve or the motor nerves of a lower extremity, such as the peroneal nerve, and observing the magnitude of resultant muscular contraction can also be used for monitoring neuromuscular function. As will be discussed later in more detail, different neuromuscular units should be monitored to assess onset of and recovery from neuromuscular block

TABLE 12-1. Tests of Neuromuscular Transmission

Peripheral nerve stimulation can be used to detect both magnitude and type of neuromuscular blockade. Quantitative conclusions must be guarded, however. Because of the wide margin of safety of neuromuscular function, a reduction in the contractile response to peripheral nerve stimulation is not quantitatively proportional to the action of relaxants at the receptor. For example, Waud and Waud ²⁷ demonstrated that the twitch response of the tibialis anterior muscle of the cat in response to a single supramaximal stimulus is not reduced unless more than 70 percent of the receptors are occupied by a nondepolarizing relaxant. Twitch is completely eliminated when 90 percent of the receptors are occupied. Furthermore, as Kopman ^{27A} demonstrated, regardless of a clinician's expertise, fade in the train-of-four (TOF) response is not reliably detected at TOF values above .40. This may lead to extubation of the trachea before adequate recovery of neuromuscular function. Despite these limitations, the response to peripheral nerve stimulation can be extremely useful. Four important questions can be answered by observing the response to peripheral nerve stimulation: (1) Is the neuromuscular blockade adequate? (2) Is the neuromuscular blockade excessive? (3) Can the neuromuscular blockade be antagonized? (4) Is the neuromuscular blockade adequately antagonized?

Whatever form of nerve stimulation is used, subtle slight degrees of neuromuscular blockade cannot be detected by observing the response of a peripheral muscle. Especially in light of recent claims that even a TOF ratio of .70 is inadequate to be considered "complete" recovery, detection of subtle degrees of neuromuscular block is important.

In order to detect subtle residual neuromuscular blockade, the neuromuscular junction must be stressed by a stimulus that is greater and longer in intensity than that used to elicit a single twitch. While a 5-second tetanic stimulus would accomplish this, tetanic stimuli are painful and are, therefore, of limited value in detecting shallow residual blockade in the unanesthetized patient.

There are multiple types of peripheral nerve stimulation. The specific pattern of stimulation used depends on the clinical purpose (e.g., monitoring of adequate relaxation versus adequate antagonism).

Muscle contraction is an all-or-none phenomenon. Each fiber either contracts maximally or does not contract at all. Therefore, when twitch height (adduction of the thumb, for example) is reduced, some fibers are contracting normally, and others are blocked and remain flaccid. The stronger the response, the fewer fibers exist in a blocked state. Fade of muscular contraction in response to tetanic stimuli suggests that some fibers are more susceptible to being blocked by relaxants and need a greater release of acetylcholine (ACh) to trigger their response.

Stimulus Variables

Because the interaction of nondepolarizing relaxants with ACh binding sites is competitive, neuromuscular blockade can be overcome by increasing, or intensified by reducing, the concentration of ACh. This basic concept is important in clinical monitoring of neuromuscular blockade. Another fundamental concept is the economy of ACh synthesis, storage, and release. The quantity of ACh released with each nerve action potential is inversely proportional to the number of action potentials reaching the nerve terminal per unit time, or the stimulus frequency. For this reason, low concentrations of nondepolarizing relaxants block responses to high-frequency peripheral nerve stimulation (e.g., 100 Hz), whereas relatively high

concentrations of relaxant are required to abolish responses elicited by low-frequency stimulation (e.g., 0.1 Hz). The depth of blockade of evoked neuromuscular responses in the presence of nondepolarizing relaxants is directly proportional to the stimulus frequency. Thus, stimuli of increasing frequency are able to detect increasingly shallow degrees of neuromuscular blockade. With rapid rates of stimulation such as tetanus at 100 Hz, very subtle degrees of block can be detected because the response to this stimulus is diminished with only very slight clinical evidence of weakness.

The pattern of response during depolarizing neuromuscular blockade is the same during slow and high rates of stimulation. Therefore, twitch and tetanic response provide essentially the same information during this type of blockade.

While monitoring nondepolarizing blockade during a typical surgical procedure, the following pattern is advised: single twitch or TOF should be followed during onset of neuromuscular blockade. TOF should be monitored during maintenance of blockade and recovery until fade in the response is no longer perceptible. Double-burst stimulation, followed by tetanic stimulation at 50 to 100 Hz, may subsequently be employed to detect more subtle degrees of residual paralysis during the final stages of recovery. Inability to reliably detect shallow residual neuromuscular blockade with either of these stimulus patterns may be due to the second and third responses to TOF stimulation influencing the clinician's interpretation of the response as well as displacement of the thumb from its baseline position with repetitive stimulation. It is imperative to confirm adequacy of function following either spontaneous or pharmacologically augmented recovery with a reliable clinical test, such as head lift for 5 seconds. This test must be performed properly, with the patient's head being lifted unaided from a true horizontal (180-degree) position. If the clinician is concerned about even more shallow degrees of block and would like to be certain that the patient has a TOF ratio greater than 85%, the ability of the patient to appose his incisor teeth should be tested.

Receptor Occlusion Techniques

Work on the subject of the fraction of receptors that may be occupied during responses to various tests of neuromuscular function was performed primarily by Waud and Waud. Although this approach is based on fundamental agonist-antagonist relationships, its main clinical value is that it allows estimation of the sensitivity of many of the tests used clinically. Even though the number of receptors occupied by a relaxant cannot be counted, Waud and Waud estimated the fraction of receptors (without knowing the absolute number of receptors) that must be unblocked by relaxant for tests of neuromuscular function to be normal. The technique estimates the fraction of receptors blocked by a nondepolarizing muscle relaxant by determining a dose-response depolarization curve from various agonist doses (succinylcholine) both in the absence and in the presence of the nondepolarizing blocker or antagonist (dTC, pancuronium). The fraction of receptors unblocked by the nondepolarizing muscle relaxant or still available for neuromuscular transmission can be estimated from the dose ratio of the agonist and blocker. For example, in the presence of dTC, 100 nmol of succinylcholine might be required to produce the same degree of depolarization produced by 10 nmol without dTC. Because ten times more succinylcholine is required with dTC, 10 percent of the receptors are still free (or 90 percent of the receptors are blocked). All other tests permit a normal response with a significant number of receptors still blocked, even at a tetanic stimulus of 200 Hz. These results suggest that no test is available to determine whether all receptors are free of a relaxant.

Respiration

The ability of a patient to maintain sustained adequate ventilation and to protect the airway, particularly during stresses such as airway obstruction or vomiting, is a main concern when looking at adequacy of recovery of neuromuscular function. Despite the enormous number of relaxant studies in the literature, few correlate tests of neuromuscular function with adequacy of ventilation, and the conclusions are often incomplete.

Johansen et al found head-lift and hand-grip strength to be 38 and 48 percent of control when both inspiratory and expiratory flow rates are greater than 90 percent of control. Furthermore, Ali et al found inspiratory force to be only 70 percent of control when vital capacity and expiratory flow rate are greater than 90 percent of control. Pavlin et al found that many of the recommended tests can return to normal while the pharyngeal and neck muscles necessary to protect the airway can still be partially paralyzed. As a result, they recommend that patients should be considered to be partially paralyzed until they can lift their head for 5 seconds or achieve a maximum negative inspiratory pressure of 35 cm H₂O (Pavlin EG, Holle RH,

Schoene RB, personal communication). A negative inspiratory force of 50 cm H₂O was found to correlate well with recovery of peripheral muscle strength.

Most recently D'Honneur et al found that with a TOF ratio of 50 percent or greater in volunteers airway patency remained at baseline values. However, in two, more recent, studies with a TOF ratio less than 90 percent, 40 percent of volunteers aspirated, and the incidence of pulmonary complications is increased in patients who had a TOF ratio less than 70 percent postoperatively. Therefore, although clinicians cannot readily detect subtle degrees of block, and patients can sustain adequate respiration before the TOF ratio has reached 90 percent, it is imperative that neuromuscular blockers be chosen and dosed in a fashion that allows for prompt recovery. Recovery room personnel need to observe the patient closely until all evidence of residual neuromuscular blockade has dissipated, and head-lift for 5 seconds is unequivocally demonstrated.

Pattern of Blockade in Muscles of the Airway

Several groups of investigators, most notably Donati et al and Pansard et al, have shown that the evolution of both depolarizing and nondepolarizing block proceeds more rapidly in the central muscles of the airway, such as the larynx (the jaw, and the diaphragm than in the more peripheral adductor of the thumb. Neuromuscular blockade develops faster, lasts a shorter time, and recovers more quickly in these muscles. Since several studies have been done that have measured the effects of neuromuscular blockers in the larynx, these data can be very useful clinically in precisely determining dosage for intubation, timing of intubation, and recovery time to levels of function compatible with airway protection.

Because neuromuscular blockade develops more rapidly in the airway than in the thumb, tracheal intubation can be performed before onset of complete block at the adductor pollicis. Onset of block in the larynx occurs 1 to 2 minutes earlier than at the adductor pollicis following administration of nondepolarizing neuromuscular blocking agents. The pattern of blockade (onset, depth, speed of recovery) in the orbicularis oculi is similar to that in the larynx. By monitoring the onset of neuromuscular blockade at the orbicularis oculi, the quality of intubating conditions can be predicted. The onset of maximal block in the larynx also corresponds with the point where the adductor pollicis is beginning to show palpable evidence of weakening. Furthermore, because recovery in the airway musculature is faster than in the thumb, one can be sure that, once monitored responses in the thumb have been correctly diagnosed as having returned to normal, the identical responses in the airway musculature have already reached that point. In other words, return of thumb responses to normal suggests that the efferent muscular arc of protective airway reflexes is intact.

Clinical Conclusion: Choice of Relaxant and Testing of Recovery

It is not known what proportion of receptors must be available or how sensitive a test must be to ensure adequate muscle strength to overcome airway obstruction and permit effective coughing. The anesthesiologist should not rely on one test but should use as many tests as is practically possible. For example, when the operative procedure is nearly finished and the patient is still under anesthesia, a tetanic stimulus of 50 Hz, TOF, twitch height, and inspiratory force may be used to determine whether a neuromuscular blockade has been antagonized completely. Then, with the patient awake, other tests, such as a 5-second head lift, can be employed. It is important to use several tests that stress the neuromuscular junction to detect subtle degrees of neuromuscular blockade. The results of Pavlin et al and the frequent return to the recovery room of patients with partial paralysis (i.e., not recognized by the anesthesiologist) emphasize the difficulty in clinically ensuring that no residual neuromuscular blockade exists after surgery and anesthesia.

TABLE 12-1. Tests of Neuromuscular Transmission

Several studies have found a much higher incidence of residual weakness in the postanesthesia care unit (PACU) following the administration of the long-acting drug pancuronium than following the use of the intermediate-duration drugs vecuronium and atracurium. The findings of these studies document the much longer time required for adequate antagonism of deep levels of block induced by long-acting muscle relaxants than by those of intermediate duration. These observations suggest that the administration of long-acting relaxants to patients whose tracheas are to be extubated at the end of a procedure should be avoided. In such cases, even in rather long procedures (4 hours), it may be wiser to provide relaxation by

infusion of intermediate or short-acting agents. The use of long-acting nondepolarizing neuromuscular blocking agents should be reserved for patients scheduled to remain intubated following lengthy and complicated procedures in order to facilitate continued mechanical ventilation in an intensive care unit or in the PACU.

Conversely, patients who are scheduled to undergo ambulatory surgical procedures and who are to be expected to function normally within minutes following the completion of the procedure should receive short- or intermediate-acting relaxants for reasons of both safety and economy (see below).

Train-of-Four Stimulation

In TOF nerve stimulation, introduced by Ali et al during the early 1970s, four supramaximal stimuli are given every 0.5 second (2 Hz). When used continuously, each set (train) of stimuli normally is repeated every 10th to 12th second. Each stimulus in the train causes the muscle to contract, and "fade" in the response provides the basis for evaluation. That is, dividing the amplitude of the fourth response by the amplitude of the first response provides the TOF ratio. In the control response (the response obtained before administration of muscle relaxant), all four responses are ideally the same: The TOF ratio is 1.0. During a partial nondepolarizing block, the ratio decreases ("fades") and is inversely proportional to the degree of blockade. During a partial depolarizing block, no fade occurs in the TOF response; ideally, the TOF ratio is approximately 1.0. Fade in the TOF response after injection of succinylcholine signifies the development of a phase II block.

The advantages of TOF stimulation are greatest during nondepolarizing blockade, as the degree of block can be read directly from the TOF response, even though a preoperative value is lacking. In addition, TOF stimulation has some advantages over tetanic stimulation: It is less painful and, unlike tetanic stimulation, generally does not affect the degree of neuromuscular blockade. However, onset and recovery of neuromuscular blockade after succinylcholine and atracurium were different with 0.08-Hz single-twitch stimulation and TOF stimulation. Although statistically significant, these differences were too small to be clinically important. Also, it has been found that increasing periods of control TOF stimulations before injection of a nondepolarizing muscle relaxant may decrease the onset time and increase the duration of clinical relaxation.

Tetanic Stimulation

Tetanic stimulation consists of very rapid (e.g., 30-, 50-, or 100-Hz) delivery of electrical stimuli. The most commonly used pattern in clinical practice is 50-Hz stimulation given for 5 seconds, although some investigators have advocated the use of 50-, 100-, and even 200-Hz stimulation for 1 second. During normal neuromuscular transmission and a pure depolarizing block, the muscle response to 50-Hz tetanic stimulation for 5 seconds is sustained. During a nondepolarizing block and a phase II block after succinylcholine, the response will not be sustained (i.e., fade occurs).

Fade in response to tetanic stimulation is normally considered a presynaptic event, and the traditional explanation is that at the start of tetanic stimulation, large amounts of acetylcholine are released from immediately available stores in the nerve terminal. As these stores become depleted, the rate of acetylcholine release decreases until equilibrium between mobilization and synthesis of acetylcholine is achieved. Despite this equilibrium, the muscle response caused by tetanic stimulation of the nerve at, for example, 50 Hz, is maintained (given normal neuromuscular transmission) simply because the release of acetylcholine is many times greater than the amount necessary to evoke a response. When the "margin of safety" of the postsynaptic membrane (i.e., the number of free cholinergic receptors) is reduced by a nondepolarizing neuromuscular blocking agent, the decrease in release of acetylcholine during tetanic stimulation produces "fade." In addition to blocking the postsynaptic receptors, nondepolarizing neuromuscular blocking drugs may also impair the mobilization of acetylcholine within the nerve terminal. This effect may contribute to the fade in the response to tetanic (and TOF) stimulation. The degree of fade depends primarily on the degree of neuromuscular blockade. Fade also depends on the frequency (Hz) and the length (seconds) of stimulation and on how often tetanic stimuli are applied. Unless these variables are kept constant, results from different studies using tetanic stimulation cannot be compared.

During partial nondepolarizing blockade, tetanic nerve stimulation is followed by a post-tetanic increase in twitch tension (i.e., post-tetanic facilitation of transmission [PTF]). This event occurs because the increase in

mobilization and synthesis of acetylcholine caused by tetanic stimulation continues for some time after discontinuation of stimulation. The degree and duration of PTF depend on the degree of neuromuscular blockade, with PTF usually disappearing within 60 seconds of tetanic stimulation. PTF is evident in electromyographic (EMG), acceleromyographic, and mechanical recordings during a partial nondepolarizing neuromuscular blockade. By contrast, post-tetanic twitch potentiation, which sometimes occurs in mechanical recordings before any neuromuscular blocking drug has been given, is a muscular phenomenon that is not accompanied by an increase in the compound muscle action potential.

Tetanic stimulation has several disadvantages. It is very painful and therefore normally not acceptable to the unanesthetized patient. Furthermore, especially in the late phase of neuromuscular recovery, tetanic stimulations may produce a lasting antagonism of neuromuscular blockade in the stimulated muscle, such that the response of the tested site may no longer be representative of other muscle groups.

Traditionally, tetanic stimulation has been used to evaluate residual neuromuscular blockade. Except in connection with the technique of post-tetanic count, however, tetanic stimulation has very little place in everyday clinical anesthesia. If the response to nerve stimulation is recorded, all the information required can be obtained from the response to TOF nerve stimulation. By contrast, if the response to nerve stimulation is evaluated only by feel or by eye (Viby-Mogensen et al, unpublished observation), even experienced observers are unable to judge the response of tetanic stimulation with sufficient certainty to exclude residual neuromuscular blockade.

Post-Tetanic Count Stimulation

Injection of a nondepolarizing neuromuscular blocking drug in a dose sufficient to ensure smooth tracheal intubation causes intense neuromuscular blockade of the peripheral muscles. Because no response to TOF and single-twitch stimulation occurs under these conditions, those modes of stimulation cannot be used to determine the degree of blockade. It is possible, however, to quantify intense neuromuscular blockade of the peripheral muscles by applying tetanic stimulation (50 Hz for 5 sec) and observing the post-tetanic response to single-twitch stimulation given at 1 Hz starting 3 seconds after the end of tetanic stimulation. During very intense blockade, there is no response to either tetanic or post-tetanic stimulation. However, when the very intense neuromuscular blockade dissipates and before the first response to TOF stimulation reappears, the first response to post-tetanic twitch stimulation occurs. For example, after injection of pancuronium (0.1 mg/kg) for tracheal intubation, the response to post-tetanic twitch stimulation appears approximately 37 minutes before the first reaction to TOF stimulation.²⁵ The corresponding figures for atracurium (0.5 mg/kg) and vecuronium (0.1 mg/kg) vary from 7 to 8 minutes.^{26, 27} As the intense block dissipates, more and more responses to post-tetanic twitch stimulation appear. For a given neuromuscular blocking drug, the time until return of the first response to TOF stimulation is related to the number of post-tetanic twitch responses present at a given time (the post-tetanic count)

The main application of the PTC method is in evaluating the degree of neuromuscular blockade when there is no reaction to single twitch or TOF nerve stimulation, as may be the case after injection of a large dose of a nondepolarizing neuromuscular blocking drug. However, PTC can also be used whenever sudden movements must be eliminated (e.g., during ophthalmic surgery). The necessary level of block of the adductor pollicis muscle to ensure paralysis of the diaphragm depends on the type of anesthesia and, in the intensive care unit (ICU), on the level of sedation. To ensure elimination of any bucking or coughing in response to tracheobronchial stimulation, neuromuscular blockade of the peripheral muscles must be so intense that no response to post-tetanic twitch stimulation can be elicited (PTC-0)

FIGURE 36-6 Relationship between the rate of muscle response to stimulation of the tracheal carina and the degree of neuromuscular blockade of peripheral muscles, as evaluated by using post-tetanic count. The subjects were 25 patients anesthetized with thiopental, nitrous oxide, and fentanyl who were given vecuronium (0.1 mg/kg) for tracheal intubation. For comparison, the first response to TOF stimulation usually occurs when PTC is approximately 10 (range, 6 to 16). The carina was stimulated with a soft sterile rubber suction catheter introduced via the endotracheal tube. The total response consisted of mild responses plus severe response. A mild response was said to occur if stimulation of the carina induced only slight bucking that did not interfere with surgery. A severe response was said to occur if stimulation elicited bucking that interfered with surgery and required intervention. Elimination of severe responses requires an intense neuromuscular blockade; PTC must be less than 2 to 3, and elimination of all reactions requires that PTC be 0.

The response to PTC stimulation depends primarily on the degree of neuromuscular blockade. It also depends on the frequency and duration of tetanic stimulation, the length of time between the end of tetanic stimulation and the first post-tetanic stimulus, the frequency of the single-twitch stimulation, and also (probably) the length of single-twitch stimulation before tetanic stimulation. When the PTC method is used, these variables should therefore be kept constant. Also, because of possible antagonism of neuromuscular blockade in the hand, tetanic stimulation should not be given more often than every 6 minutes. If the hand muscles undergo antagonism of neuromuscular blockade while the rest of the body is still paralyzed, the hand muscles are no longer useful for monitoring.

Double-Burst Stimulation

DBS was developed with the specific aim of allowing manual (tactile) detection of small amounts of residual neuromuscular blockade under clinical conditions. During recovery from neuromuscular blockade, the degree of residual block can be evaluated from recorded responses to TOF nerve stimulation. Without recording equipment, however, it is not possible by visual or tactile means to evaluate the TOF response with certainty to exclude shallow degrees of residual neuromuscular blockade. With DBS (as opposed to TOF stimulation), it is easier to “feel” fade in the response.

DBS consists of two short bursts of 50-Hz tetanic stimulation separated by 750 ms. The duration of each square wave impulse in the burst is 0.2 ms. Although the number of impulses in each burst can vary, initial studies indicate that DBS with three impulses in each of the two tetanic bursts (DBS3,3) is suitable for clinical use. Studies are currently evaluating the suitability of other types of DBS.

In nonparalyzed muscle, the response to DBS3,3 is two short muscle contractions of equal strength. In the partly paralyzed muscle, the second response is weaker than the first (i.e., the response fades). Measured mechanically, the TOF ratio correlates closely with the DBS3,3 ratio. During recovery and immediately after surgery, tactile evaluation of the response to DBS3,3 is superior to tactile evaluation of the response to TOF stimulation. However absence of fade in the manually evaluated response to DBS3,3 does not exclude residual neuromuscular blockade.

FIGURE 36–8 Fade detectable by feel in the response to TOF and double-burst stimulation (DBS3,3) in relation to the true TOF ratio, as measured mechanically. The axis indicates the percentage of instances in which fade can be felt at a given true TOF ratio. A TOF ratio of 0.70 to 0.75 is normally taken to reflect adequate recovery of neuromuscular function, so that ideally fade should be felt in all patients with a TOF ratio below 0.7 and in no patients with a ratio above 0.7 (the “ideal curve”).

TEST ACCEPTABLE CLINICAL RESULT TO SUGGEST NORMAL FUNCTION/APPROXIMATE PERCENTAGE OF RECEPTORS OCCUPIED WHEN RESPONSE RETURNS TO NORMAL VALUE//COMMENTS/DISADVANTAGES/ADVANTAGES

- Tidal volume at least 5 mL/kg/80%//Insensitive as an indicator of peripheral neuromuscular function.
- Single twitch strength Qualitatively as strong as baseline/75–80%// Uncomfortable, need to know twitch strength before relaxant administration. Insensitive as an indicator of recovery, but useful as a gauge of deep neuromuscular blockade.
- Train-of-four (TOF) No palpable fade/70–75%// Still uncomfortable, but more sensitive as an indicator of recovery than single twitch. Useful as a gauge of depth of block by counting the number of responses perceptible.
- Sustained tetanus at 50 Hz for 5 seconds No palpable fade/ 70%//Very uncomfortable, but a reliable indicator of adequate recovery.
- Vital capacity At least 20 mL/kg/70%//Requires patient cooperation, but is the goal for achievement of full clinical recovery.
- Double-burst stimulation No palpable fade/ 60–70%// Uncomfortable, but more sensitive than TOF as an indicator of peripheral function. No perceptible fade indicates TOF of at least recovery of 60%.
- Sustained tetanus at 100 Hz No palpable fade/ 50%// Very painful, a “stress test” for the neuromuscular junction. It is not always possible to achieve or to demonstrate lack of fade at 100 Hz.
- Inspiratory force At least –40 cm H₂O/ 50%// Sometimes difficult to perform without endotracheal intubation, but a reliable gauge of normal diaphragmatic function.

- Head lift Must be performed unaided with patient supine at 180° and sustained for 5 seconds/
50%// Requires patient cooperation, but remains the standard test of normal clinical function.
Must be performed with the patient in a completely supine position.
- Hand grip Sustained at a level qualitatively similar to preinduction baseline/ 50%//
Sustained strong grip, though also requiring patient cooperation. Is another good gauge of normal function.
- Sustained bite Sustained jaw clench on tongue blade/ 50%// Very reliable with patient cooperation. Corresponds with TOF of 85%.

Neuromuscular Physiology and Pharmacology

INTRODUCTION

The physiology of neuromuscular transmission could be analyzed and understood at the most simple level by using the classic model of nerve signaling to muscle via the acetylcholine receptor. Yet recent research has provided more detailed information on these processes, which, within the classic scheme, can modify neurotransmission or response to drugs, or both. One example of this would be the role of qualitative or quantitative changes in acetylcholine receptors modifying neurotransmission and response to drugs. [1](#) In myasthenia gravis, for example, the decrease in acetylcholine receptors results in decreased efficiency of neurotransmission (and therefore muscle weakness) and altered sensitivity to neuromuscular relaxants. [1, 2](#) At still another level is the evidence that muscle relaxants act in ways that are not encompassed by the classic scheme of unitary site of action: The observation that muscle relaxants can have prejunctional effects, [3](#) or that some nondepolarizers can also have agonist-like stimulatory actions on the receptor, [4](#) has provided new insights into some previously unexplained observations. Although this multifaceted action-response scheme makes the physiology and pharmacology of neurotransmission more complex, these added insights also bring experimentally derived knowledge much closer to clinical observations.

Crucial to the seminal concepts that have developed relative to neurotransmitter, acetylcholine, and its receptor systems have been the introduction of powerful and contemporary techniques in molecular biology, immunology, and electrophysiology. These have augmented the more traditional pharmacologic, protein chemical, and cytologic approaches. [5](#) Additionally, recent research has elucidated the manner in which the nerve ending regulates not only the synthesis and release of transmitter but also trophic factors, both of which control muscle function, and how these processes are influenced by exogenous and endogenous substances. [1, 6, 7, 8](#) Research continues into how receptors are synthesized and anchored at the end plate, the role of the nerve terminal in the maturation process, and the synthesis and control of acetylcholinesterase, the enzyme that breaks down acetylcholine. The reader is referred to several recent reviews that provide detailed insights into these areas. [7, 8, 9, 10](#)

Neuromuscular transmission occurs by a fairly simple and straightforward mechanism. The nerve synthesizes acetylcholine and stores it in small, uniformly sized packages called *vesicles*. Stimulation of the nerve causes these vesicles to migrate to the surface of the nerve, rupture, and discharge acetylcholine into the cleft separating nerve from muscle. Acetylcholine receptors in the end plate of the muscle respond by opening its channels for influx of sodium ions into the muscle to depolarize the muscle. The end plate potential thus created is continued along the muscle membrane by the opening of the sodium channels present throughout the muscle membrane, initiating a contraction. [11](#) The acetylcholine immediately detaches from the receptor and is destroyed by acetylcholinesterase enzyme, which also is in the cleft. Drugs, notably depolarizing relaxants or carbachol, can also act on these receptors to mimic the effect of acetylcholine and cause depolarization of the end plate. These drugs are, therefore, called *agonists* of the receptor, since to a greater or lesser extent, at least initially, they stimulate the receptor. Nondepolarizing relaxants also act on the receptors, but they prevent acetylcholine from binding to the receptor and so prevent depolarization by agonists. Since these nondepolarizers prevent the action of agonists (e.g., acetylcholine, succinylcholine), the nondepolarizers are also referred to as *antagonists* of the acetylcholine receptor. Other compounds, frequently called *reversal agents* (e.g., neostigmine), inhibit acetylcholinesterase enzyme and therefore impair the hydrolysis of acetylcholine. The increased accumulation of undegraded acetylcholine can effectively compete with nondepolarizing relaxants, displacing the latter from the receptor (law of mass action), antagonizing the effects of nondepolarizers.

Select an item below

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Morphology

Section 2: Scientific Principles

Part D: Physiology and Anesthesia

Chapter 20: Neuromuscular Physiology and Pharmacology

Morphology

The neuromuscular junction is specialized, both on the nerve side and on the muscle side, to transmit and receive chemical messages. [2](#), [3](#), [4](#), [5](#), [6](#), [7](#) Each motoneuron runs without interruption from the ventral horn of the spinal cord to the neuromuscular junction as a large myelinated axon. As it approaches the muscle, it branches repeatedly to contact many muscle cells and to gather them into a functional group known as a motor unit. The architecture of the nerve terminal is quite different from that of the rest of the axon. As the terminal reaches the muscle fiber, it loses its myelin to form a spray of terminal branches against the muscle surface and is covered by Schwann cells. [7](#), [9](#) This arrangement conforms to the architecture on the synaptic area of muscle membrane ([Fig. 20–1](#)). The nerve is separated from the surface of the muscle by an approximate 20 nm gap, *the junctional cleft*. The nerve and muscle are held in tight alignment by protein filaments, which span the cleft between nerve and end plate. The muscle surface is heavily corrugated, with deep invaginations of the junctional cleft—the primary and secondary clefts—between the folds in the muscle membrane; thus, the end plate's total surface area is very large. The shoulders of the folds are densely populated with acetylcholine receptors, about 5 million of them in each junction. These receptors are sparse in the depths between the folds. Instead, these deep areas contain sodium channels.

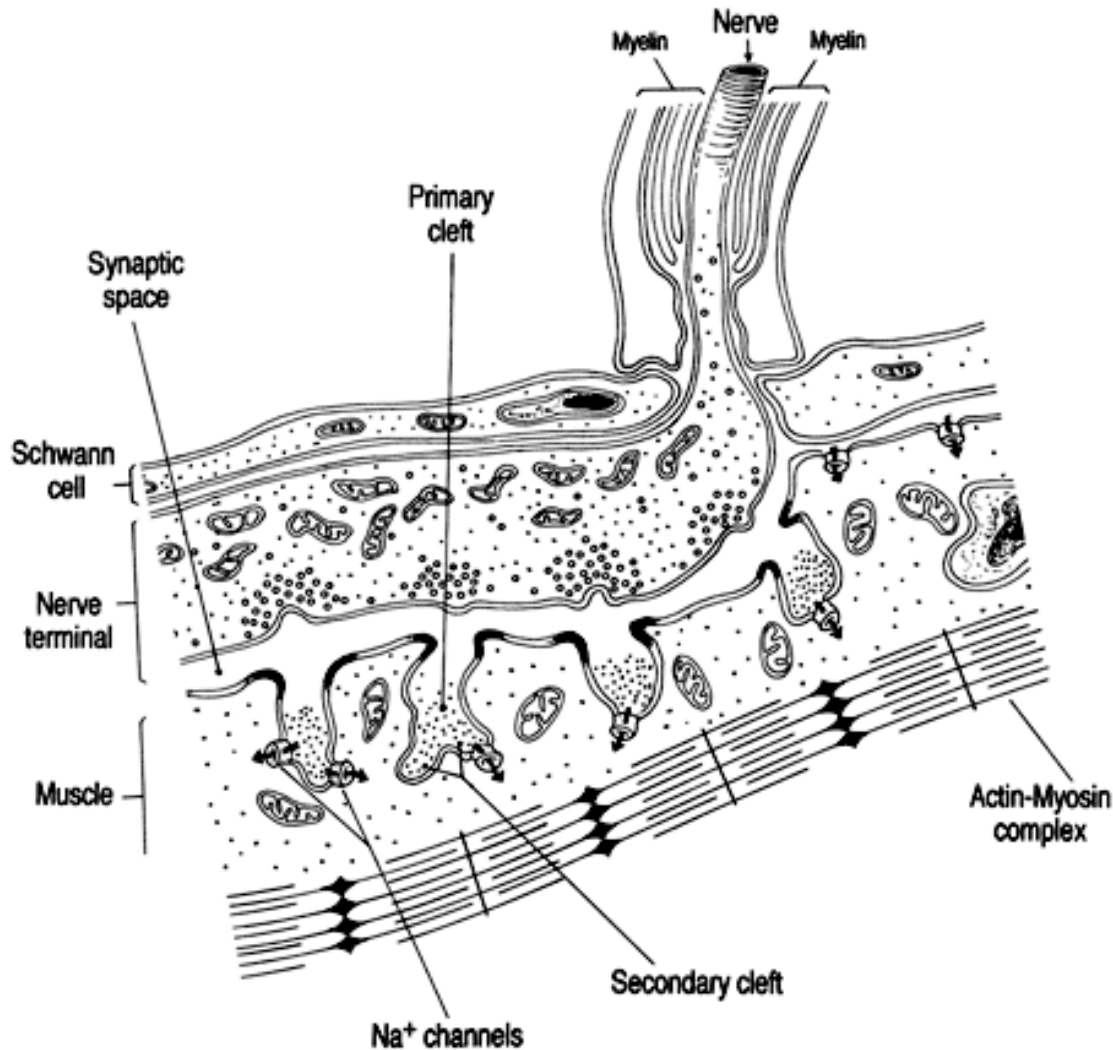


FIGURE 20-1 Adult neuromuscular junction with the three cells that constitute the synapse: the motor neuron (nerve terminal), muscle fiber, and Schwann cell. The motor neuron from the ventral horn of the spinal cord innervates the muscle. Each fiber receives only one synapse. The motor nerve loses its myelin to terminate on the muscle fiber. The nerve terminal covered by a Schwann cell has vesicles clustered about the membrane thickenings, which are the active zones, toward its synaptic side, and mitochondria and microtubules toward its other side. A synaptic gutter, made up of a primary and many secondary clefts, separates the nerve from the muscle. The muscle surface is corrugated, and dense areas on the shoulders of each fold contain acetylcholine receptors. The sodium channels are present at the clefts and throughout muscle membrane.

The trophic function of the nerve is most vital for the development and maintenance of adequate neuromuscular function. Before birth, each muscle cell commonly has contacts with several nerves and thus has several neuromuscular junctions. At birth, all but one of the nerves retract and a single end plate remains. Once formed, however, the nerve-muscle contact, especially the end plate, is durable. Even if the original nerve dies, the one replacing it innervates exactly the same region of the muscle. The nerve endings on fast muscles are larger and more complicated than those on slow muscles. The reason for this is unclear. These differences in the nerve endings on the muscle surfaces may play a role in the differences in the response to muscle relaxants of fast and slow muscles.

Since all the muscle cells in a unit are excited by a single neuron, stimulation of the nerve either electrically or via an action potential originating from the ventral horn, or by any agonist, including depolarizing relaxants

(e.g., succinylcholine), causes all muscle cells in the motor unit to contract synchronously. The synchronous contraction of the cells in a motor unit is fasciculation and often is vigorous enough to be observed through the skin. Although most adult human muscles have only one neuromuscular junction per cell, an important exception is some of the cells in the extraocular muscles. The extraocular muscles are “tonic” muscles, and, unlike other mammalian striated muscles, they are multiply innervated, with several neuromuscular junctions strung along the surface of each muscle cell. These muscles contract and relax slowly, rather than quickly as other striated muscles do; indeed, they can maintain a steady contraction, or contracture, whose strength is proportional to the stimulus received. Physiologically, this apparently is a specialization that holds the eye steadily in position. These muscles are important to an anesthetist because depolarizing relaxants affect them differently than they do most skeletal muscles. Instead of causing a brief contraction followed by paralysis, the drugs cause long-lasting contracture response, which pulls the eye against the orbit and contributes to a rise in the pressure of the intraocular fluid. [12](#)

The *perijunctional zone* is the area of muscle between and around the receptive area, and it is critical to the function of the neuromuscular junction. The perijunctional zone contains a mixture of the receptors, which include a smaller density of acetylcholine receptors and high-density sodium channels. The admixture enhances the capacity of the perijunctional zone to respond to the depolarization (end plate potential) produced by acetylcholine receptors and to transduce it into the wave of depolarization that travels along the muscle to initiate muscle contraction. The density of sodium channels in the perijunctional area is richer than in more distal parts of the muscle membrane. [13](#) The perijunctional zone is close enough to the nerve ending to be influenced by transmitter released from it. Moreover, special variants (isoforms) of receptors (see [Biology of Prejunctional and Postjunctional Nicotinic Receptors](#)) and sodium channels can appear in this area at different stages of life and in response to abnormal decreases in nerve activity. Congenital abnormalities in the acetylcholine receptor or the sodium channels (mutations) are also known. [11, 14](#) These variabilities seem to contribute to the differences in response to relaxants that are seen in patients of differing pathologic conditions and ages. [1, 15](#) These qualitative differences may also play a role in altered muscle function (see [Myopathy of Critical Illness](#)).

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Quantal Theory

The contents of the ending are not homogeneous. As diagrammatically illustrated in [Figure 20–1](#), the vesicles are congregated in the portion toward the junctional surface, whereas the microtubules, mitochondria, and other support structures are located toward the opposite side. The vesicles containing the transmitter are ordered in repeating clusters alongside small, thickened, electron-dense patches of membrane referred to as an *active zone*. This thickened area is a cross-section of a band running across the width of the synaptic surface of the nerve ending, believed to be the structure to which vesicles attach before they rupture into the junctional cleft. High-resolution scanning electron micrographs reveal small protein particles arranged alongside the active zone, between vesicles. These are believed to be special channels, the voltage calcium channels, that allow calcium to enter the nerve and cause the release of vesicles. [16](#)

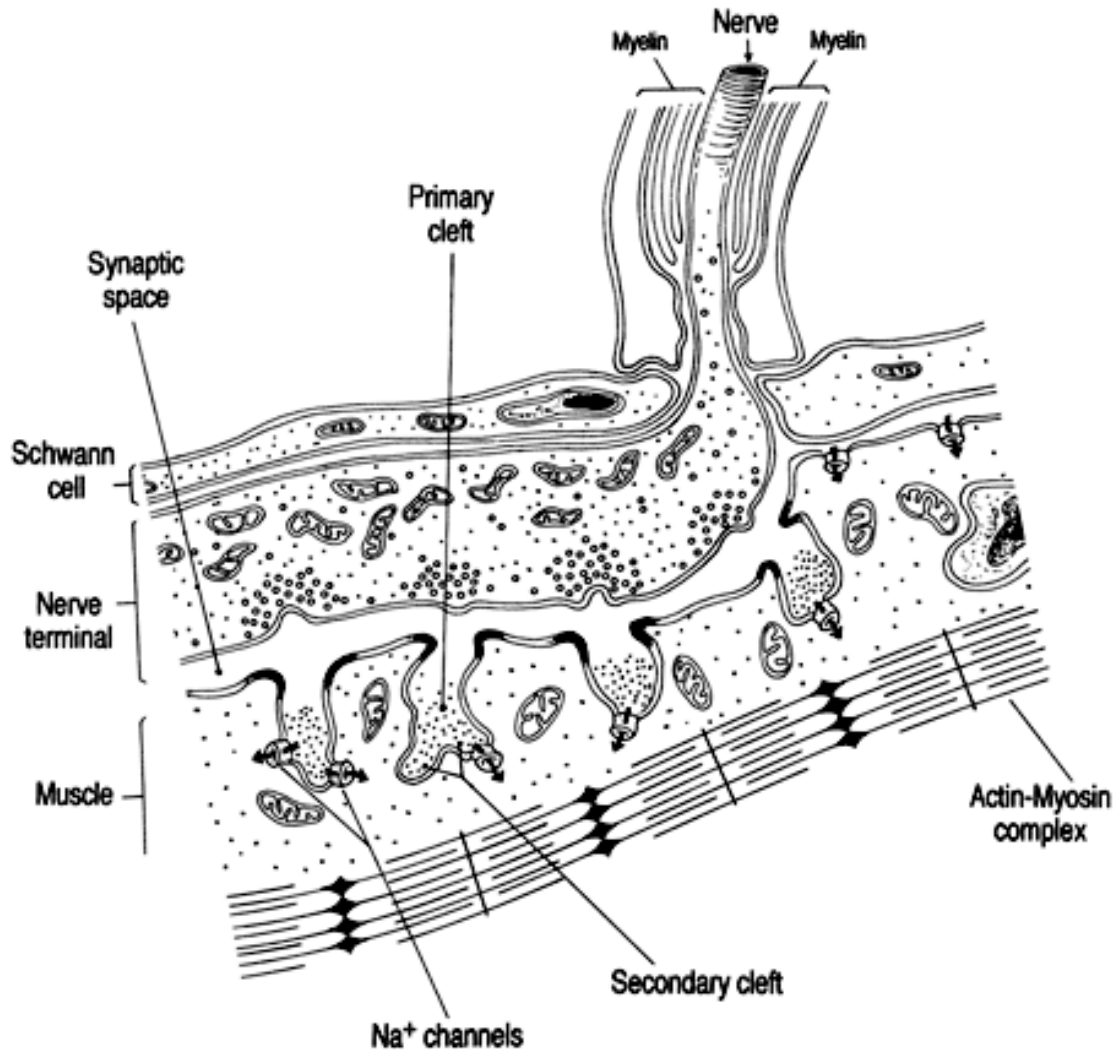


FIGURE 20-1 Adult neuromuscular junction with the three cells that constitute the synapse: the motor neuron (nerve terminal), muscle fiber, and Schwann cell. The motor neuron from the ventral horn of the spinal cord innervates the muscle. Each fiber receives only one synapse. The motor nerve loses its myelin to terminate on the muscle fiber. The nerve terminal covered by a Schwann cell has vesicles clustered about the membrane thickenings, which are the active zones, toward its synaptic side, and mitochondria and microtubules toward its other side. A synaptic gutter, made up of a primary and many secondary clefts, separates the nerve from the muscle. The muscle surface is corrugated, and dense areas on the shoulders of each fold contain acetylcholine receptors. The sodium channels are present at the clefts and throughout muscle membrane.

When one observes the electrophysiologic activity of a skeletal muscle, small, spontaneous, depolarizing potentials at neuromuscular junctions can be seen. These potentials have only one-one hundredth the amplitude of the evoked end plate potential produced when the motor nerve is stimulated. Except for amplitude, these potentials resemble the end plate potential in time course and in the manner in which they are affected by drugs. Therefore, these small amplitude potentials are called miniature end plate potentials (MEPP). Statistical analysis led to the conclusion that they are unitary responses; that is, there is a minimum size for the MEPP, and the sizes of all MEPPs are either equal to or multiples of this minimum size. Because MEPPs are too big to be produced by a single molecule of acetylcholine, it was deduced that they are produced by uniformly sized packages, or quanta, of transmitter released from the nerve (in the absence of stimulation). The stimulus-evoked end plate potential is the additive depolarization produced by the synchronous discharge of quanta from several hundred vesicles. The action potential that is propagated to

the nerve ending allows the entry of calcium in the nerve through voltage-gated calcium channels, and this causes vesicles to migrate to the active zone, fuse with the neural membrane, and discharge their acetylcholine into the junctional cleft. **16, 17** Since the release sites are located immediately opposite the receptors on the postjunctional surface, little transmitter is wasted, and the response of the muscle is coupled very directly with the signal from the nerve. The amount of acetylcholine released by each nerve impulse is large, at least 200 quanta of about 5,000 molecules each, and the number of acetylcholine receptors activated by the transmitter released by a nerve impulse also is large, about 500,000. The ions (mostly Na^+ and some Ca^{2+}) that flow through the channels of the activated receptors cause a maximum depolarization of the end plate, which in turn causes an end plate potential that is greater than the threshold for stimulation of the muscle. This is a very vigorous system. The signal is carried by more molecules of transmitter than are needed, and these evoke a response that is greater than needed. At the same time, only a small fraction of the available vesicles and receptors/channels are used to send each signal. Consequently, transmission has a substantial margin of safety, and at the same time the system has substantial capacity in reserve.

Section 2: Scientific Principles

Part D: Physiology and Anesthesia

Chapter 20: Neuromuscular Physiology and Pharmacology

THE NEUROMUSCULAR JUNCTION

Motor Nerve Endings

The axon of the motor nerve carries not only electrical signals from the spinal cord to the muscles but also all the biochemical apparatus needed to transform the electrical signal into a chemical one. All the ion channels, enzymes, other proteins, macromolecules, and membrane components needed by the nerve ending to synthesize, store, and release acetylcholine and other trophic factors are made in the cell body and are transmitted to the nerve ending by axonal transport (**Fig. 20-2**). **7, 9** The simple molecules choline and acetate are obtained from the environment of the nerve ending, the former by a special system that transports it from the extracellular fluid to the cytoplasm and the latter in the form of acetylcoenzyme A from mitochondria. The enzyme choline acetyltransferase brings about the reaction of choline and acetate to form acetylcholine, which is stored in cytoplasm until it is transported into vesicles, which are more into position for release. During a nerve action potential, sodium flows across the membrane and the resulting depolarizing voltage opens calcium channels, which allow entry of the calcium ion into the nerve and cause the release of acetylcholine.

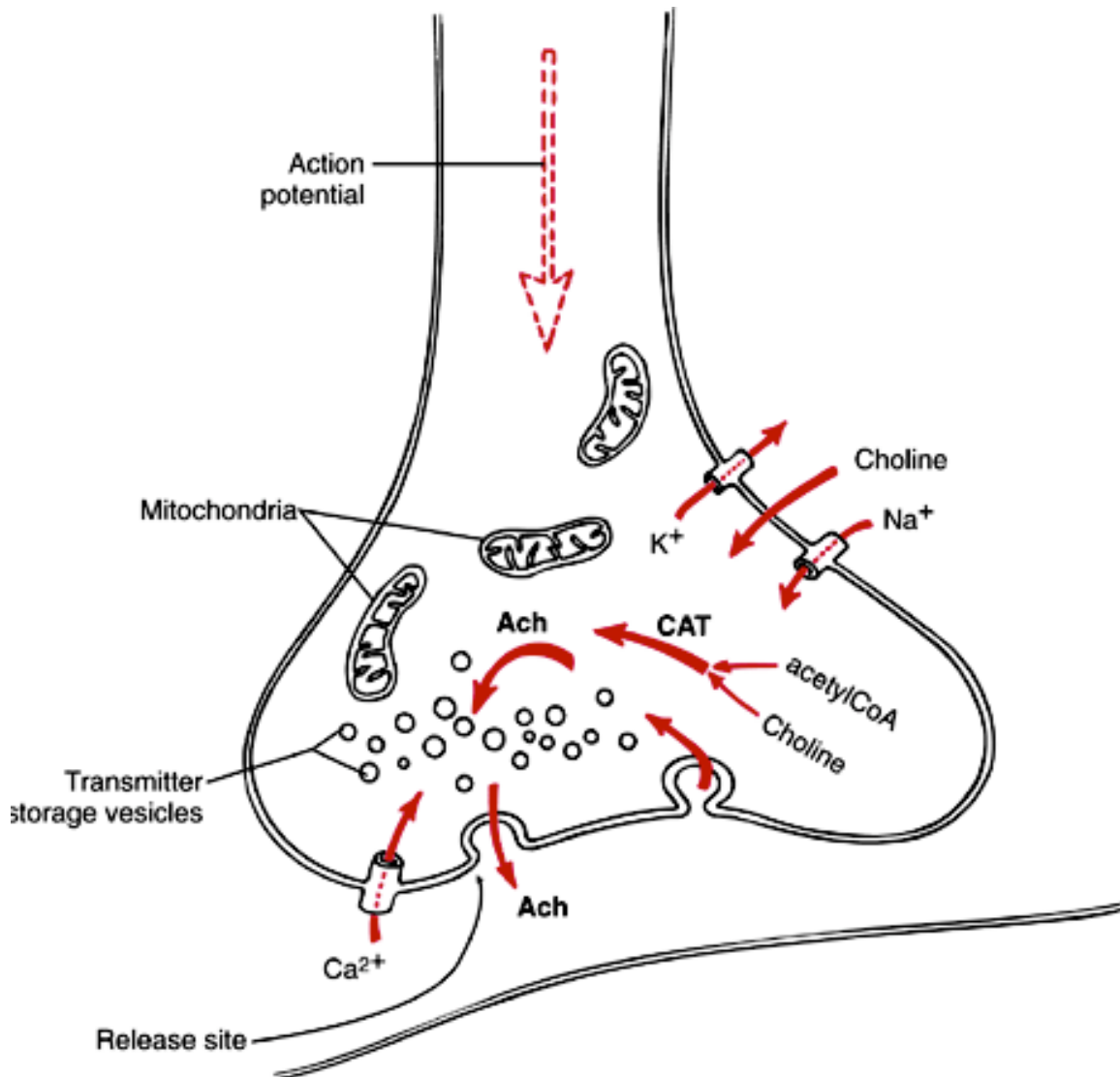


FIGURE 20–2 The working of a chemical synapse, the motor nerve ending, including some of the apparatus for transmitter synthesis. acetylCoA, acetyl coenzyme A; Ach, acetylcholine; CAT, choline acetyltransferase. Large intracellular structures are mitochondria. Acetylcholine, synthesized from choline and acetylcoenzyme A, is transported into coated vesicles, which are moved to release sites. A presynaptic action potential, which triggers calcium influx through specialized proteins (Ca^{2+} channels), causes the vesicles to fuse with the membrane and discharge transmitter. Membrane from the vesicle is retracted from the nerve membrane and recycled. The transmitter is inactivated by diffusion, catabolism, or reuptake.

A nerve action potential is the normal activator that releases transmitter, acetylcholine. The number of quanta released by a stimulated nerve is greatly influenced by the concentration of ionized calcium in the extracellular fluid. If calcium is not present, depolarization of the nerve, even by electrical stimulation, will not produce release of transmitter. Doubling the extracellular calcium results in a 16-fold increase in the quantal content of an end plate potential. The calcium *current* persists until the membrane potential is returned to normal by outward fluxes of potassium from inside the nerve cell. Thus, the calcium current can be prolonged by potassium channel blockers (e.g., 4-aminopyridine, and tetraethylammonium), which slow or prevent potassium efflux out the nerve. The increase in quantal content produced in this way can reach astounding proportions. **18** An effect of increasing the calcium in the nerve ending is also seen clinically as the so-called *post-tetanic potentiation*, which occurs after a nerve of a patient paralyzed with a nondepolarizing relaxant is stimulated at high, tetanic frequencies. Calcium enters the nerve with every stimulus, but it cannot be excreted as quickly as the nerve is stimulated and so accumulates during the

tetanic period. Since the nerve ending contains more than the normal amount of calcium for some time after the tetanus, a stimulus applied to the nerve during this time causes the release of more than the normal amount of acetylcholine. The abnormally large amount of acetylcholine antagonizes the relaxant and causes the characteristic increase in the size of the twitch.

Calcium enters the nerve via specialized proteins called *calcium channels*. [8](#) Of the several types of calcium channels, two seem to be important for transmitter release, the P channels and the slower L channels. The P channels, probably the type responsible for the normal release of transmitter, are found only in nerve terminals. [8, 19](#) In motor nerve endings they are located immediately adjacent to the active zones (see [Fig. 20-2](#)). They are voltage-dependent (i.e., they are opened and closed by the changes in membrane voltage caused by the nerve action potential). Alterations in calcium entry into nerve ending can also alter release of transmitter. Eaton-Lambert myasthenic syndrome is an acquired autoimmune disease in which antibodies are directed against the voltage-gated calcium channel at nerve endings. [20](#) In this syndrome, the decreased function of the calcium channel causes decreased release of transmitter, resulting in inadequate depolarization and therefore muscle weakness. Patients with myasthenic syndrome exhibit increased sensitivity to depolarizing and nondepolarizing relaxants. [1](#)

Tiny concentrations of bivalent inorganic cations (e.g., magnesium, cadmium, manganese) can also block calcium entry through P channels and profoundly impair neuromuscular transmission. This is the mechanism for muscle weakness in the mother and fetus when magnesium sulfate is administered to treat preeclampsia. The P channels, however, are *not* affected by calcium entry-blocking drugs, such as verapamil, diltiazem, and nifedipine. These drugs have profound effects on the slower L channels present in the cardiovascular system. As a result, the L-type calcium channel blockers at *therapeutic* doses have no significant effect on the normal release of acetylcholine or on the strength of normal neuromuscular transmission. There have been a few reports, however, that calcium entry-blocking drugs may increase the block of neuromuscular transmission induced by nondepolarizing relaxants. The effect is small, and not all investigators have been able to observe it. The explanation may lie in the fact that nerve endings also contain L-type calcium channels.

There seem to be two pools of vesicles that release acetylcholine, a readily releasable store and a reserve store, sometimes called VP2 and VP1, respectively. [7, 21](#) The vesicles in the former are a bit smaller and are limited to an area very close to the nerve membrane, where they probably are bound to the active zones. These vesicles are the ones that ordinarily release transmitter. The release seems to occur when calcium ion enters the nerve via the P channels lined up on the sides of the active zones. [21](#) This calcium needs to move only a very short distance (i.e., a few atomic radii), to encounter a vesicle and to activate a protein, *synaptophysin*, in the vesicle wall. [22](#) The activated protein seems to react with the nerve membrane to form a pore, through which the vesicle discharges its acetylcholine into the junctional cleft.

The majority of the vesicles in the nerve ending are the larger “reserve” vesicles. These are firmly tethered to the *cytoskeleton* by proteins, the *synapsins*. From their position on the cytoskeleton, they may be moved to the readily releasable store to replace worn-out vesicles or to participate in transmission when the nerve is called upon to work especially hard (e.g., when it is stimulated at very high frequencies or for a very long time). Under such strenuous circumstances, calcium may penetrate more deeply than normal into the nerve or may enter via L channels to activate calcium-dependent enzymes, which cause breakage of the synapsin links that hold the vesicles to the cytoskeleton, thereby allowing the vesicles to be moved to the release sites. Repeated stimulation requires the nerve ending to replenish its stores of vesicles filled with transmitter, a process known as *mobilization*. The term commonly is applied to the aggregate of all steps involved in maintaining the nerve ending’s capacity to release transmitter—everything from the acquisition of choline and the synthesis of acetate to the movement of filled vesicles to the release sites. The uptake of choline as well as the activity of choline acetyltransferase, the enzyme that synthesizes acetylcholine, probably are the rate-limiting steps. [7, 8, 9, 16, 17, 18, 19](#)

Acetylcholinesterase

The acetylcholine released from the nerve diffuses across the junctional cleft and reacts with specialized receptor proteins in the end plate to initiate muscle contraction. Transmitter molecules that do not react immediately with a receptor or that are released after binding to the receptor are destroyed almost instantly by the acetylcholinesterase in the junctional cleft. Acetylcholinesterase is an asymmetric protein made in the muscle, under the end plate. It is secreted from the muscle but remains attached to it via thin stalks of

collagen fastened to the basement membrane. [7](#), [10](#) Most of the molecules of acetylcholine released from the nerve initially pass between the enzymes to reach the postjunctional receptors, but as they are released from the receptors, they invariably encounter acetylcholinesterase and are destroyed. Under normal circumstances, a molecule of acetylcholine reacts with only one receptor before it is hydrolyzed. Acetylcholine is a potent messenger, but its actions are very short-lived because it is destroyed in less than 1 millisecond after it is released.

Postjunctional Receptors

The similarity of the acetylcholine receptors among many species and the abundance of acetylcholine receptors from the *Torpedo* electric fish have greatly facilitated research in this area. The availability of the messenger ribonucleic acids (mRNAs) of humans and other species and of deoxyribonucleic acids (DNAs) has allowed the study of the receptor in artificial systems such as oocytes from frogs and mammalian cells that do not express the receptor (e.g., COS or fibroblast cells). It is also possible, by molecular techniques, to mutate receptors to simulate pathologic states and then study receptor function in these artificial systems. By using these and related techniques, a great deal has been learned about the synthesis, composition, and biologic function and the mechanisms that underlie physiologic and pharmacologic responses in the acetylcholine receptors. [4](#), [23](#), [24](#), [25](#) It is now evident that two isoforms of postjunctional receptors exist, a junctional or mature and an extrajunctional or immature receptor. [1](#), [7](#) (See **Biology of Prejunctional and Postjunctional Nicotinic Receptors**.) The differences between receptor subtypes, however, can be neglected in a general discussion of the role of receptors in neuromuscular transmission.

The acetylcholine receptors are synthesized in muscle cells and are anchored to the end plate membrane by a special protein known as the 43-Kd protein. The receptors, formed of five subunit proteins, are arranged like the staves of a barrel into a cylindrical receptor with a central pore for ion channeling. The key features are sketched in [Fig. 20-3](#). The receptor protein is about 250,000 d molecular weight. Each receptor has five subunits, which are designated α , β , δ , and ϵ or γ ; there are two subunits of α and one of each of the others. [1](#), [7](#) Each of the subunits consists of approximately 400 to 500 amino acids. The receptor protein complex passes entirely through the membrane and protrudes both beyond the extracellular surface of the membrane and also into the cytoplasm. The binding site for acetylcholine is on each of the α -subunits, and these are the sites of competition between the receptor agonists and antagonists. Both agonists and antagonists are attracted to the binding site and either may occupy the site, which is located near cysteine residues (unique to the α -chain) at amino acid positions 192-193 of the α -subunit. [26](#) Radiolabeled α -bungarotoxin from the cobra is used to quantitate the receptor that binds to heptapeptide region 189-199 of the α -subunit. [27](#)

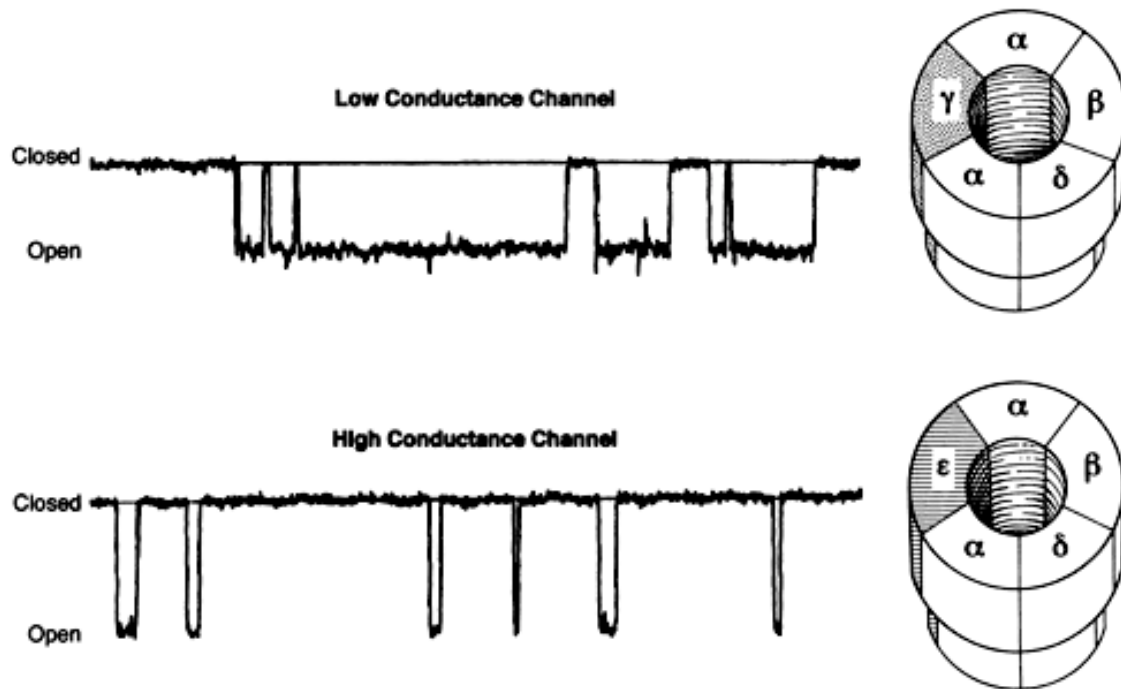


FIGURE 20-3 Sketch of acetylcholine receptor channels (right) and tracings of cell patch records of receptor channel openings (left). The mature, or junctional, receptor consists of two α -subunits and one each of β -, ϵ -, and δ - subunits. The immature, extrajunctional or fetal form consists of two α -subunits and one each of β , γ , and δ . The subunits are arranged around the central cation channel. The immature isoform containing the γ -subunit shows long open times and low amplitude channel currents. The mature isoform containing the ϵ -subunit shows shorter open times and high amplitude channel currents. Substitution of the ϵ -subunit for the γ -subunit gives rise to the fast-gated, high conductance channel type.

Progress in electrophysiologic techniques have moved *pari passu* with advances in molecular approaches to study the receptor. Patch clamping is a technique in which a glass micropipette is used to probe the membrane surface until a single functional receptor is encompassed. The tip of the pipette is pressed into the lipid of the membrane, and the electronic apparatus is arranged to keep the membrane potential clamped (fixed) and to measure the current that flows through the channel of the receptor. The solution in the pipette can contain acetylcholine, tubocurarine, another drug, or a mixture of drugs. By application of these drugs to the receptor via the micropipette, electrical changes could be monitored.

Figure 20-4 illustrates the results of the classical depolarizing action of acetylcholine on end plate receptors. Normally, the pore of the channel is closed by the approximation of the cylinders (subunits). When **both** α -subunit sites are occupied by an agonist, the protein molecule undergoes a conformation change that forms a channel in the center through which ions can flow along a concentration gradient (see **Fig. 20-4**). When the channel is open, there is a flow of sodium and calcium from the outside of the cell to the inside, and of potassium from the inside to the outside. The channel in the tube is large enough to accommodate many cations and electrically neutral molecules, but it excludes anions (e.g., chloride). The current carried by the ions depolarizes the adjacent membrane. The net current is depolarizing and creates the end plate potential that stimulates the muscle to contract. In this instance, downward-going (depolarizing) rectangular pulses (see **Fig. 20-3**) can be recorded by the electrophysiologic technique described previously.

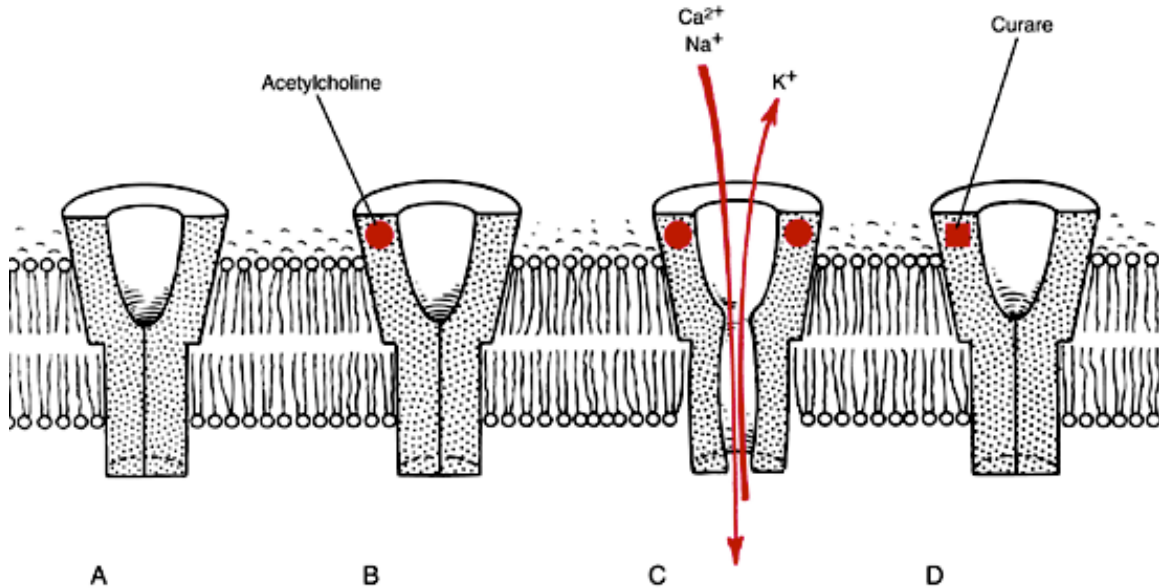


FIGURE 20–4 The actions of acetylcholine or curare on end plate receptors. (A) The ion channel is inactive and does not open in the absence of acetylcholine. (B) Even the binding of one acetylcholine (•) to one of two binding sites does not open the channel. (C) When acetylcholine binds to recognition sites of *both* α -subunits simultaneously (•), it triggers a conformation change that opens the channel and allows ions to flow across the membrane. (D) The action of antagonists (e.g., curare, bold square). Acetylcholine is in competition with tubocurarine for the receptor's recognition site but may also react with acetylcholinesterase. Inhibiting the enzyme increases the lifetime of acetylcholine and the probability that it will react with a receptor. When one of the two binding (recognition) sites is occupied by curare, the receptor will not open, even if the other binding site is occupied by acetylcholine.

The pulse stops when the channel closes and one or both agonist molecules detach from the receptor. The current that passes through each open channel is minuscule, only a few picoamperes (about 10^4 ions per millisecond). However, each burst of acetylcholine from the nerve normally opens about 500,000 channels simultaneously, and the total current is more than adequate to produce depolarization of the end plate and contraction of muscle. Thus, the opening of a channel causes the conversion of chemical signals from a nerve to current flows to end plate potentials, leading to muscle contraction. We are used to thinking of the end plate potential as a graded event, which may be reduced in magnitude or extended in time by drugs, but in reality the end plate potential is the summation of many all-or-nothing events occurring simultaneously at a myriad of individual ion channels. It is these tiny events that are affected by drugs.

Receptors that do not have two molecules of agonists bound, remain closed. Both α -subunits must be occupied simultaneously by agonist; if only one of them is occupied, the channel remains closed (see [Fig. 20–4](#)). This is the basis for the prevention of depolarization by antagonists. Drugs such as tubocurarine act by binding to either, or both, α -subunits and in so doing preventing acetylcholine from binding and opening the channel. This interaction between agonists and antagonists is competitive, and the outcome—transmission or block—depends on the relative concentrations and binding characteristics of the drugs involved (see [Drug Effects on Postjunctional Receptors](#)).

Individual channels are also capable of a wide variety of conformations. [28, 29](#) Most simply, they may open or stay closed, thus affecting total current flow across the membrane. However, they can do more. They may open for a longer or shorter time than normal, open or close more gradually than usual, open briefly and repeatedly (chatter), or pass fewer or more ions per opening than they usually do. Also, their function is influenced by drugs, changes in the fluidity of the membrane, temperature, the electrolyte balance in the milieu, and other physical and chemical factors. [30](#) Thus, receptor-channels are dynamic structures that are capable of a wide variety of interactions with drugs and of entering a wide variety of current-passing states. All these influences on channel activity ultimately are reflected in the strength or weakness of neuromuscular transmission and the contraction of a muscle.

DRUG EFFECTS ON POSTJUNCTIONAL RECEPTORS

Classical Actions of Nondepolarizing Muscle Relaxants

Neurotransmission occurs when the action potential releases acetylcholine and binds to the receptor. All nondepolarizing relaxants impair or block neurotransmission by competitively preventing the binding of acetylcholine to its receptor. The final outcome (block or transmission) is dependent on the relative concentrations of the chemicals and their comparative affinities for the receptor. **Figure 20–4** shows a system exposed to acetylcholine and tubocurarine. One receptor has attracted two acetylcholine molecules and opened its channel where current will flow to depolarize that segment of membrane. Another has attracted one tubocurarine molecule; its channel will not open, and no current will flow, even if one acetylcholine molecule binds to the other site. The third receptor has acetylcholine on one α -subunit and nothing on the other. What will happen depends on which of the molecules binds. If acetylcholine binds, the channel will open and the membrane will be depolarized; if tubocurarine binds, the channel will stay closed and the membrane will not be depolarized. At other times, one or two tubocurarine molecules may attach to the receptor, in which case the receptor is not available to agonists; no current flow is recorded. In the presence of moderate concentrations of tubocurarine, the amount flowing through the entire end plate at any instant is reduced from normal, which results in a smaller end plate potential and, if carried far enough, a blockade of transmission.

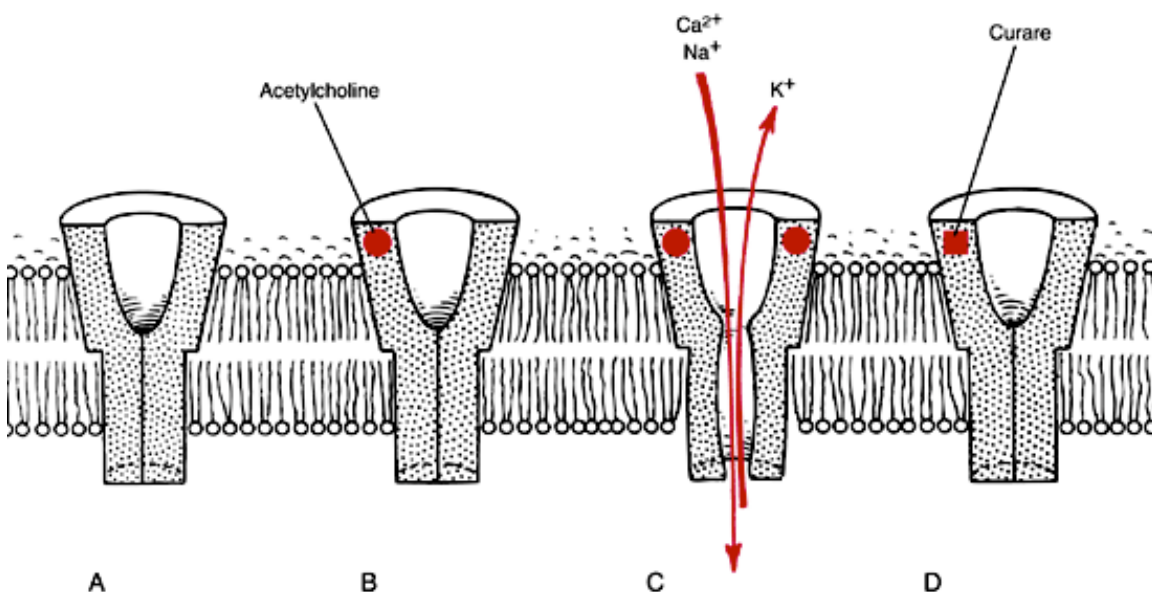


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Normally, acetylcholinesterase enzyme destroys acetylcholine and removes it from the competition for a receptor, so that tubocurarine has a better chance of inhibiting transmission. If, however, an inhibitor such as neostigmine is added, the cholinesterase cannot destroy acetylcholine. The concentration of agonist in the cleft remains high, and this high concentration shifts the competition between acetylcholine and tubocurarine in favor of the former, thus improving the chance of two acetylcholine molecules binding to a receptor even though tubocurarine is still in the environment. This is the mechanism by which cholinesterase inhibitors overcome the neuromuscular paralysis produced by nondepolarizing relaxants. It must be noted, however, that the channel opens only when acetylcholine attaches to both the recognition sites. A single molecule of antagonist, however, is adequate to prevent the depolarization of that receptor. This modifies the competition by biasing it strongly in favor of the antagonist. Mathematically, if the concentration of

tubocurarine is doubled, the concentration of acetylcholine must be increased 4-fold if acetylcholine is to remain competitive. This means that paralysis produced by high concentrations of antagonist is more difficult to reverse than those produced by low concentrations. Following large doses of nondepolarizing relaxants, reversal drugs may be ineffective until the concentration of the relaxant in the perijunctional area decreases to a lower level by either redistribution or elimination of the drug.

Classical Action of Depolarizing Muscle Relaxants

Depolarizing relaxants, at least initially, simulate the effect of acetylcholine and therefore can be considered agonists despite the fact that they block neurotransmission after initial stimulation. Structurally, succinylcholine is actually two molecules of acetylcholine bound together. It is, therefore, not surprising that it can mimic the effects of acetylcholine. Succinylcholine or decamethonium can bind to the receptor, open the channel, pass current, and depolarize the end plate. These agonists, similar to acetylcholine, attach only briefly; so each opening of a channel is of very short duration, 1 millisecond or less. The response to acetylcholine, however, is over in milliseconds because of its rapid degradation by acetylcholinesterase, and the end plate resets to its resting state long before another nerve impulse arrives. In contrast, the depolarizing relaxants characteristically have a biphasic action on muscle—an initial contraction, followed by relaxation lasting minutes to hours. The depolarizing relaxants, since they are not susceptible to hydrolysis by acetylcholinesterase, are not eliminated from the junctional cleft until after they are eliminated from the plasma. The time required to clear the drug from the body is the principal determinant of how long the drug effect lasts. Whole body clearance of the relaxant is very slow, as compared with the acetylcholine, even when the plasma cholinesterase is normal. Since relaxant molecules are not cleared from the cleft quickly, they react repeatedly with receptors, attaching to one almost immediately after separating from another, thereby repeatedly depolarizing the end plate and opening channels.

The quick shift from excitation of muscle contraction to blockade of transmission by depolarizing relaxants occurs even though—indeed because—the end plate is continuously depolarized. This comes about because of the juxtaposition at the edge of the end plate on the muscle membrane—a different kind of ion channel, the sodium channel that does not respond to chemicals but opens when they are exposed to a transmembrane voltage change. The sodium channel is also a cylindrical transmembrane protein, through which sodium ions can flow through. Two parts of its structure act as gates that allow or stop the flow of sodium ions. **31** Both gates must be open if sodium is to flow through the channel; the closing of either cuts off the flow. Because these two gates act sequentially, a sodium channel has three functional conformation states and can move progressively from one state to another (counterclockwise in **Fig. 20–5**).

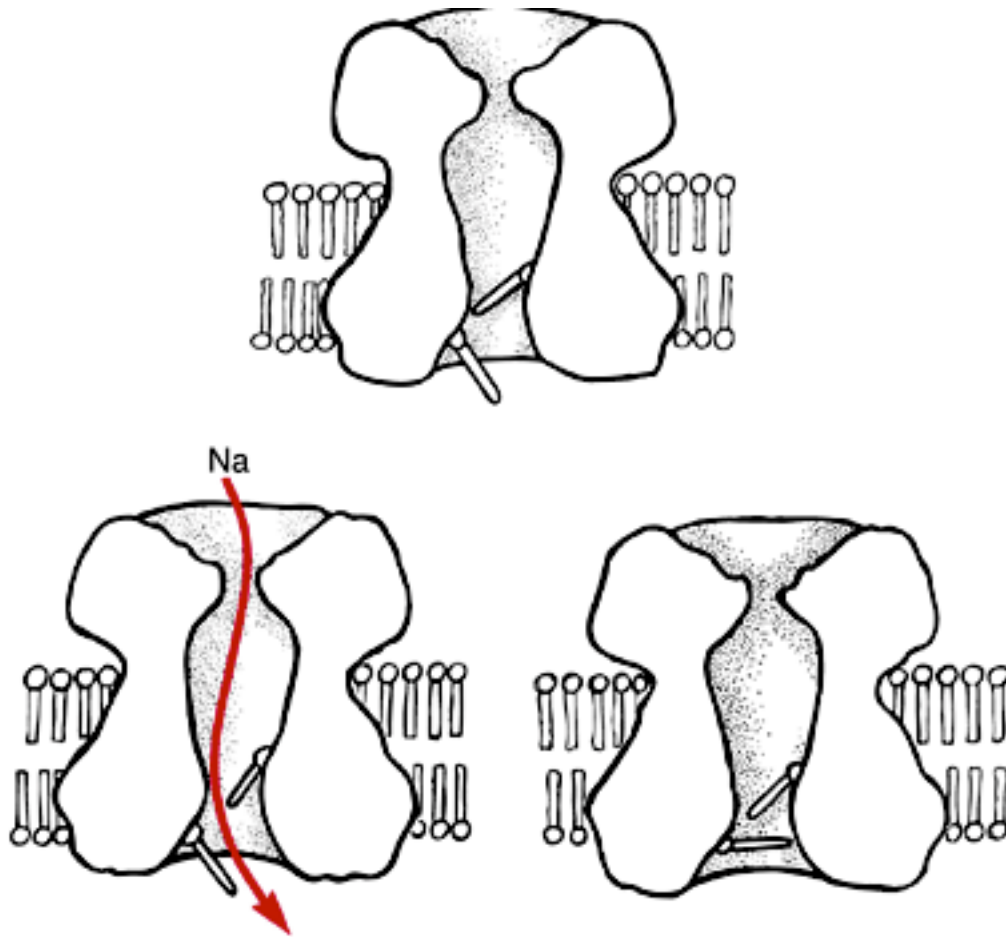


FIGURE 20-5 Sketch of sodium channel. The bars represent parts of the molecule that act as gates. The upper one is voltage dependent; the lower one is time dependent. The top drawing represents the resting state. Once activated by a voltage change, the molecule and its gates progress as illustrated but only in the counterclockwise direction (see text for details).

When the sodium channel is in its resting state, the lower gate (called the time-dependent or inactivation gate) is open, but the upper gate (the voltage-dependent gate) is closed, and sodium ions cannot pass. When the molecule is subject to a sudden change in voltage by depolarization of the adjacent membrane, the top gate opens and, since the bottom (time-dependent) gate is still open, sodium flows through the channel. The voltage-dependent gate stays open as long as the molecule is subject to a depolarizing influence from the membrane around it; it will not close until the depolarization disappears. However, shortly after the voltage-dependent gate opens, the bottom gate closes and again cuts off the flow of ions. It cannot open again until the voltage-dependent gate closes. When the depolarization of the end plate stops, the voltage-dependent gate closes, the time-dependent one opens, and the sodium channel returns to its resting state. This whole process is short-lived when depolarization occurs with acetylcholine. The initial response of a depolarizing muscle relaxant resembles that of acetylcholine, but since the relaxant is not hydrolyzed rapidly, depolarization of the end plate is not brief.

The depolarization of the end plate by the relaxant initially causes the voltage gate in adjacent sodium channels to open, causing a wave of depolarization to sweep along the muscle, causing muscle contraction. Shortly after the voltage-dependent gate opens, the time-dependent inactivation gate closes. Since the relaxant is not removed from the cleft, the end plate continues to be depolarized. Since the sodium channels immediately adjacent to the end plate are influenced by the depolarization of the end plate, their voltage-dependent gates stay open and consequently their inactivation gates stay closed. Since sodium cannot flow through a channel that has a closed inactivation gate, the perijunctional muscle membrane does not depolarize. When the flow of ions through the sodium channels in the perijunctional zone stops because the inactivation gates have closed, the channels downstream (beyond the perijunctional zone) are freed of

depolarizing influence. In effect, the perijunctional zone becomes a buffer that shields the rest of the muscle from events at the end plate. Consequently, the muscle membrane is separated into three zones: the end plate, which is depolarized by succinylcholine; the perijunctional muscle membrane, in which the sodium channels are frozen in an inactivated state; and the rest of the muscle membrane, in which the sodium channels are in the resting state. Since a burst of acetylcholine from the nerve cannot overcome the inactivated sodium channels in the perijunctional zone, neuromuscular transmission is blocked. This phenomenon is also called *accommodation*. During accommodation, when the synapse is inexcitable via the nerve (transmitter), direct electrical stimulation of muscle will cause muscle contraction, since the sodium channels beyond the junctional area are in the resting excitable state.

The extraocular muscles contain tonic muscle, which is multiply innervated and chemically excitable along most of its surface. Accommodation does not occur, and these muscles can undergo a sustained contracture in the presence of succinylcholine. The tension so developed forces the eye against the orbit and accounts for part of the rise in intraocular pressure produced by depolarizing relaxants. There is also evidence that the extraocular muscles contain a special type of receptor that does not become desensitized (see subsequent discussion) in the continued presence of acetylcholine or other agonists. [32](#)

Nonclassical and/or Noncompetitive Actions of Neuromuscular Drugs

Several drugs can interfere with the receptor, directly or via its lipid environment, to change transmission. These drugs react with the neuromuscular receptor to change its function and to impair transmission, but do not act via the acetylcholine binding site. These reactions cause drug-induced changes in the dynamics of the receptor so that instead of opening and closing sharply, the modified channels are sluggish. They open more slowly and stay open longer or they close slowly and in several steps, or both. These effects on channels cause corresponding changes in the flow of ions and distortions of the end plate potential. The clinical effect depends on the molecular events. For example, procaine, ketamine, inhaled anesthetics, or other drugs that dissolve in the membrane lipid may change the opening or closing characteristics of the channel. [33](#), [34](#) If the channel is prevented from opening, transmission is weakened. If, on the other hand, the channel is prevented from or slowed in closing, transmission may be enhanced. They do not fit the classic model and the impaired neuromuscular function is not antagonized by increasing perijunctional acetylcholine concentrations with cholinesterase inhibitors. Such drugs can be involved in two clinically important reactions, receptor *desensitization* and *channel blockade*. The former occurs in the receptor molecule, while the latter occurs in the ion channel.

Desensitization Block

The acetylcholine receptor, because of its flexibility and the fluidity of the lipid around it, is capable of existing in a number of conformational states. [30](#), [33](#), [34](#), [35](#) The resting receptor is free of agonist, so its channel is closed. The second state is when two molecules of agonists are bound to the α -subunit of the receptor, and the receptor has undergone the conformation change that opens the channel and allows ions to flow. These reactions are the bases of normal neuromuscular transmission. Some receptors that bind to agonists, however, do not undergo the conformation change to open the channel. Receptors in these states are termed *desensitized* (i.e., they are not sensitive to the channel-opening actions of agonists). They bind agonists, indeed, with exceptional avidity, but the binding does not result in the opening of the channel. The mechanisms by which desensitization occurs are not known. The receptor macromolecule, 1,000 times larger by weight than most drugs or gases, provides many places at which the smaller molecules may act. The interface between lipid and receptor protein provides additional potential sites of reaction. Several different conformations of the protein are known, and because acetylcholine cannot cause the ion channel to open in any of them, they all are included in the functional term *desensitization*. Some evidence suggests that desensitization is accompanied by phosphorylation of a tyrosine unit in the receptor protein. [36](#)

Although agonists (e.g., succinylcholine) induce desensitization, the receptors are in a constant state of transition between resting and desensitized states whether or not agonists are present. Agonists do promote the transition to a desensitized state or, because they bind very tightly to desensitized receptors, trap a receptor in a desensitized state. Antagonists also bind tightly to desensitized receptors and can trap molecules in these states. This action of antagonists is not competitive with that of acetylcholine; in fact, it may be augmented by acetylcholine if the latter promotes the change to a desensitized state. Desensitization can lead to significant misinterpretations of data. Superficially, the preparation seems to be normal, but its responsiveness to agonists or antagonists is altered. One variety occurs very rapidly, within a

few milliseconds after application of an agonist. This may explain the increased sensitivity to nondepolarizers after prior administration of succinylcholine. There also is the phenomenon caused by prolonged administration of depolarizing relaxants and known as phase II block (see under **Phase II Block**). This frequently is referred to as a desensitization blockade but should not be, because desensitization of receptors is only one of many phenomena that contribute to the process.

Many other drugs used by anesthetists also promote the shift of receptors from a normal state to a desensitized state. **33, 34, 35** These drugs, some of which are listed in **Table 20–1**, can weaken neuromuscular transmission by reducing the margin of safety that normally exists at the neuromuscular junction, or they can cause an apparent increase in the capacity of nondepolarizing agents to block transmission. These actions are independent of the classic effects based on competitive inhibition of acetylcholine. The presence of desensitized receptors means that fewer receptor-channels than usual are available to carry transmembrane current. Therefore, the production of desensitized receptors decreases the efficacy of neuromuscular transmission. If many receptors are desensitized, insufficient normal ones are left to depolarize the motor end plate, and neuromuscular transmission will not occur. Even if only some receptors are desensitized, neuromuscular transmission will be impaired, and the system will be more susceptible to block by conventional antagonists such as tubocurarine or pancuronium.

TABLE 20–1. Some Drugs That Can Cause or Promote Desensitization of Nicotinic Cholinergic Receptors

VOLATILE ANESTHETICS

Halothane
Methoxyflurane
Isoflurane

ANTIBIOTICS

Polymyxin B

COCAINE

ALCOHOLS

Ethanol
Butanol
Propanol
Octanol

BARBITURATES

Thiopental
Pentobarbital

AGONISTS

Acetylcholine
Decamethonium
Carbachol
Succinylcholine

AChE INHIBITORS

Neostigmine
Pyridostigmine
DFP

LOCAL ANESTHETICS

Dibucaine
Lidocaine
Prilocaine
Etidocaine

PHENOTHIAZINES

Chlorpromazine
Trifluoperazine
Prochlorperazine

PHENCYCLIDINE

CA²⁺ CHANNEL BLOCKERS

Verapamil

Channel Block

Local anesthetics and calcium entry blockers block the flow of sodium or calcium through their respective channels. Thus, the term *channel-blocking drugs*. Similarly, a block to the flow of ions can occur at the acetylcholine receptor with concentrations of drugs used clinically and may contribute to some of the phenomena and drug interactions seen at the receptor. Two major types, closed channel and open channel block, can occur. **37, 38** In closed channel block, certain drugs can occupy the mouth of the channel and by their presence prevent physiologic ions from passing through the channel to depolarize the end plate. The process can take place even when the channel is not open. In open channel block, a drug molecule enters a channel that has been opened by reaction with acetylcholine but does not necessarily penetrate all the way through. Open channel blockade is use-dependent, which means that molecules can enter the channel only when it is open. In both open and closed channel block, the normal flow of ions through receptor is impaired, resulting in prevention depolarization of the end plate and a weaker or blocked neuromuscular transmission. However, since the action is not at the acetylcholine recognition site, it is not a competitive antagonism of acetylcholine and is not relieved by anticholinesterases that increase concentrations of acetylcholine. Indeed, increasing the concentration of acetylcholine may cause the channels to open more often and thereby become more susceptible to blockade by use-dependent compounds. In this regard, there is evidence that neostigmine and related cholinesterase inhibitors themselves can act as channel-blocking drugs. **37, 38**

Channel blockade is believed to play a role in some of the antibiotics, cocaine, quinidine, piperocaine, tricyclic antidepressants, naltrexone, naloxone, and histronicotoxin-induced alterations in neuromuscular function. Muscle relaxants, in contrast, can bind to the acetylcholine recognition site of the receptor and also occupy the channel. Pancuronium preferentially binds to the recognition site. Gallamine seems to act equally at the two sites. Tubocurarine is in between: At low doses, those that produce minimal blockage of transmission clinically, the drug is essentially a pure antagonist at the recognition site; at larger doses, it also enters and blocks channels. Decamethonium and succinylcholine as agonists can open channels and as slender molecules also enter and block them. In fact, decamethonium and some other long, thin molecules can penetrate all the way through the open channel and enter the muscle cytoplasm. Whether prolonged administration of nondepolarizers, as in the intensive care situation, can result in entry of the relaxant, occupation of the channel, and finally entry of drug into the cytosol is unknown. This effect may partially explain the muscle weakness associated with relaxant therapy in the intensive care unit.

Phase II Block

Phase II block is a complex phenomenon that occurs slowly at junctions continuously exposed to depolarizing agents. The junction is depolarized by the initial application of a depolarizing relaxant, but then the membrane potential gradually recovers toward normal, even though the junction is still exposed to drug. Neuromuscular transmission usually remains blocked throughout the exposure. Several things seem to be involved. The repeated opening of channels allows a continuous efflux of potassium and influx of sodium, and the resulting abnormal electrolyte balance distorts the function of the junctional membrane. Calcium entering the muscle via the opened channels can cause disruption of receptors and sub-end plate elements themselves. On the other hand, the activity of a sodium-potassium adenosine triphosphatase pump in the membrane increases with increasing intracellular sodium and, by pumping sodium out of the cell and potassium into it, works to restore the ionic balance and membrane potential toward normal. As long as the depolarizing drug is present, the receptor channels remain open and ion flux through them remains high. **39**

Factors influencing the development phase II block include the duration of exposure to the drug, the particular drug used and its concentration, and even the type of muscle (i.e., fast or slow). Interactions with anesthetics and other agents also affect the process. All of these drugs may also have prejunctional effects on the rate and amount of transmitter release and mobilization. With so many variables involved in the interference with neuromuscular transmission, phase II block is a complex and ever-changing phenomenon. Thus, the reversal response of a phase II block produced by a depolarizing muscle relaxant to administration of cholinesterase inhibitors is difficult to predict. It is, therefore, best that reversal by cholinesterase inhibitors is not attempted, although the response to tetanus or train-of-four stimulation resembles that produced by nondepolarizers.

BIOLOGY OF PREJUNCTIONAL AND POSTJUNCTIONAL NICOTINIC RECEPTORS

Immature/Extrajunctional Versus Mature/Junctional Isoforms

As already indicated, there are two isoforms (variants) of the postjunctional acetylcholine receptors. The acetylcholine receptor isoform present in the innervated, adult neuromuscular junction is referred to as the adult, mature, or junctional receptor. When there is decreased activity in muscle, as seen in the fetus before innervation, following lower or upper motor neuron injury, after burns or sepsis, or after other events that cause increased muscle protein catabolism, another isoform is expressed. ⁴⁰ To contrast with the mature, junctional receptors, the other isoform is referred to as the immature, extrajunctional, or fetal form of acetylcholine receptor. (Indirect evidence suggests that this immature isoform is not seen in muscle protein catabolism and wasting occurring with malnutrition.) ⁴¹ The differences in the protein structure of the isoforms cause significant qualitative variations among the responses of individual patients to relaxants and seem to be responsible for some of the anomalous results that are observed when administering relaxants to particular individuals. These qualitative differences in the isoforms can also cause variations in function of muscle. ¹⁴

The structural composition and other characteristics differ between the two isoforms. ^{1, 7, 40} At the molecular level, both types of receptors consists of five subunits (see **Fig. 20-3**). The mature junctional receptor is a pentamer of two α -subunits and one each of the β -, δ -, and ϵ -subunits. The immature receptor consists of two α , and each of β , δ and γ -subunits. That is, in the immature receptor the γ -subunit is present instead of the ϵ -subunit. The γ - and ϵ -subunits differ from each other very little in amino acid homology, but the differences are great enough to affect the physiology and pharmacology of the receptor and its ion channel. Although the names junctional and extrajunctional imply that each is located in the junctional and extrajunctional areas, this is not strictly correct. Junctional receptors are always confined to the end plate (perijunctional) region of the muscle membrane. The immature, or extrajunctional, receptor may be expressed anywhere in the muscle membrane. Despite the name *extrajunctional*, they are not excluded from the end plate. During development and in certain pathologic states, the junctional and extrajunctional receptors can coexist in the perijunctional area of the muscle membrane (**Fig. 20-6**).

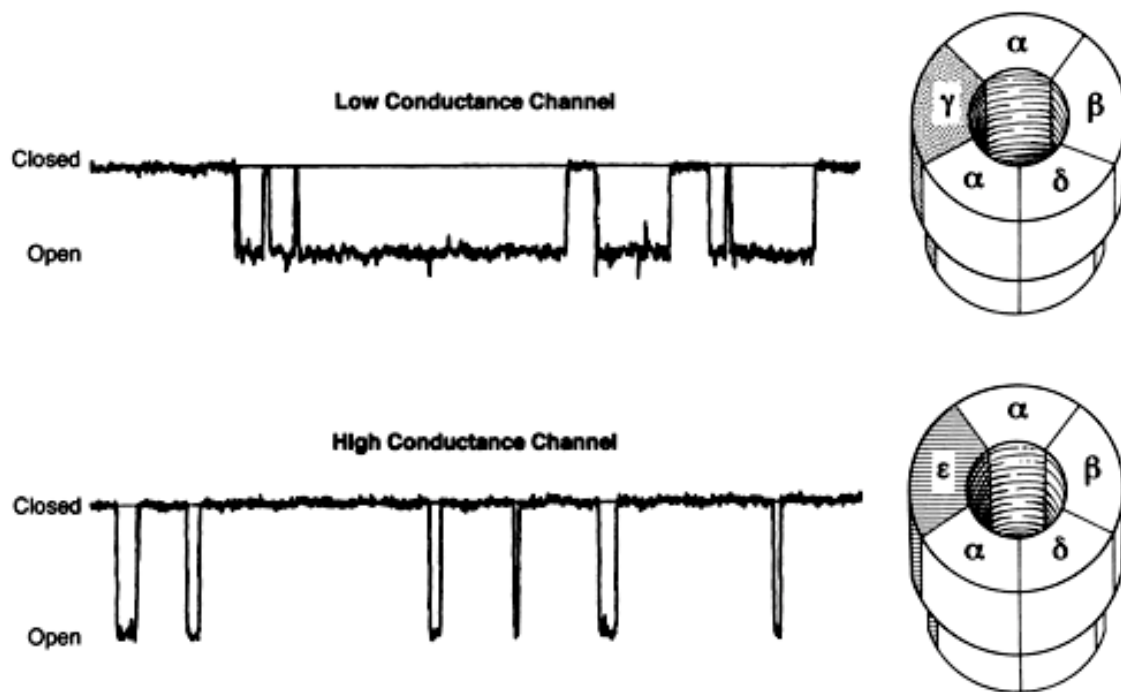


FIGURE 20-3 Sketch of acetylcholine receptor channels (right) and tracings of cell patch records of receptor channel openings (left). The mature, or junctional, receptor consists of two α -subunits and one each of β -, ϵ -, and δ -subunits. The immature, extrajunctional or fetal form consists of two α -subunits and one each of β -, γ -, and δ -. The subunits are arranged around the central cation channel. The immature isoform containing the γ -subunit shows long open times and low amplitude channel currents. The mature isoform containing the ϵ -

subunit shows shorter open times and high amplitude channel currents. Substitution of the ϵ -subunit for the γ -subunit gives rise to the fast-gated, high conductance channel type.

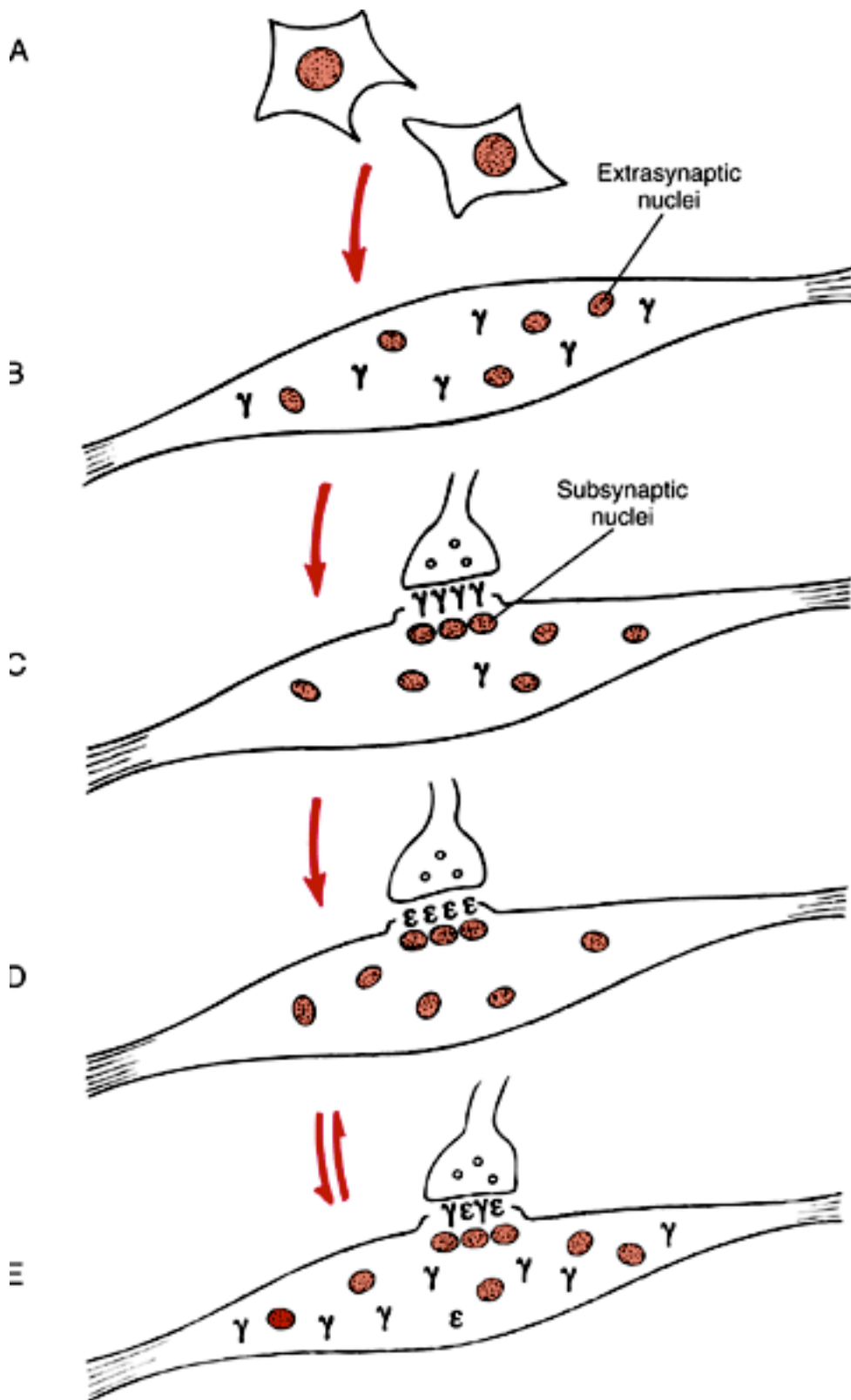


FIGURE 20–6 Distribution of acetylcholine receptors in developing adult, mature, and denervated muscle. (A and B) In the early fetal stage, mononucleated myoblasts, derived from the mesoderm, fuse to form multinucleated myotubes. The g-subunit containing immature acetylcholine receptors are scattered throughout the muscle membrane. (C) As the nerve makes contact with muscle, clustering of the receptors occurs at the synapse associated with some loss of extra synaptic receptors. (D) Maturation of the junction is said to occur when e-subunit-containing receptors replace the g-subunit-containing receptors. Note that even mature muscle is multinucleated, but is devoid of extrasynaptic nuclei. (E) Denervation or some other pathologic states (burns, sepsis) leads to reexpression of the g-subunit receptor, at both the junctional and the extrajunctional areas. The latter changes are potentially reversible.

Quite in contrast to other cells, muscle cells are unusual in that they have many, usually hundreds of, nuclei per cell. Each of these nuclei has the genes to make both types of receptors. Multiple factors, including electrical activity, growth factor signaling, and presence or absence of innervation, control the expression of the two types of receptor isoforms. [6, 7, 8, 42](#) This is most clearly seen in the developing embryo, as the neuromuscular junction is formed. Before they are innervated, the muscle cells of a fetus synthesize only the immature receptors, hence the term fetal isoform of receptor. The synthesis is directed by nearly all the nuclei in the cell, and the receptors are expressed throughout the membrane of the muscle cell (see [Fig. 20–6](#)). As the fetus develops and the muscles become innervated, muscle cells begin to synthesize mature isoform of receptors, which are inserted exclusively into the developing (future) end plate area. The nerve releases several growth factors that influence the synthetic apparatus of the nearby nuclei. First, nerve-supplied factors induce the subsynaptic nuclei to increase synthesis of the acetylcholine receptors. Next the nerve-induced electrical activity results in repression of receptors in the extrajunctional area. Finally, the nerve-derived factors cause the clustering of the receptors in the subsynaptic area. [5, 7, 42](#) The innervation process progresses somewhat slowly during fetal life and infancy. [15](#) With time, the immature receptors diminish in concentration and disappear from the peripheral part of the muscle. A child is usually about 2 years old before nerve-muscle contacts are mature. Thus, in the active, adult, normal, innervated muscle, only the nuclei under and very near the end plate direct the synthesis of receptor; only the genes for expressing the mature receptors are active. The nuclei beyond the junctional area are not active and therefore no receptors are expressed anywhere in the muscle cells beyond the perijunctional area.

Proteins implicated in the linking of the mature receptors to the cytoskeleton include urotrophin, α - and β -dystroglycan, and rapsyn. Several lines of evidence indicate that the clustering, expression, and stabilization of the mature receptors is triggered by at least three growth factors, agrin, acetylcholine receptor inducing activity, and calcitonin-gene related peptide. [6, 7, 42](#) Agrin is also released from the muscle, but muscle-derived agrin does not seem to be as important in the clustering and maturation of the receptor. The synapsins are made in the nerve and seem to play a role in the maturation of vesicular arrangement. All of these growth factors interact with distinct membrane and cytosolic receptor proteins causing phosphorylation, activation of nuclear (gene) transcriptional systems. These in turn control qualitative and quantitative changes at the junction. Once begun, the process is very stable; that is, these nuclei in the junctional area continue to express mature receptors.

The extrajunctional receptors can reappear soon after upper and lower motor denervation and in certain pathologic states (burns, immobilization, loss of electrical activity). The appearance of the immature receptors can be prevented by stimulating a denervated muscle with an external electrical stimulus. It has been suggested that the calcium that enters the muscle during activity is important to the suppression process. In the pathologic states just enumerated, if the process is severe and prolonged, extrajunctional receptors are inserted all over the surface of the muscle, including the perijunctional area. The junctional nuclei also continue to make mature receptors. The end plates thus will consist now of both mature and immature receptors. The synthesis of immature receptors is initiated within hours of inactivity, but it takes several days for the whole muscle membrane to be fully quoted with receptors. This upregulation of receptors has implications for the use of both depolarizing and nondepolarizing relaxants.

The changes in subunit composition (g versus e) in the receptor confer certain changes in electrophysiologic (functional), pharmacologic, and metabolic characteristics. [1, 7](#) The mature receptors are metabolically stable, with half-life approximating 2 weeks, whereas the immature receptor has a metabolic half-life of less than 24 hours. Immature receptors have a smaller single-channel conductance and a 2- to 10-fold longer mean channel open time than mature receptors (see [Fig. 20–3](#)). The changes in subunit composition may also alter the sensitivity or affinity, or both, of the receptor for specific ligands. Depolarizing or agonist drugs such as succinylcholine and acetylcholine depolarize immature receptors more easily, resulting in cation

fluxes; one-tenth to one-hundredth doses, necessary for mature receptors, can effect depolarization. Potency of nondepolarizers is also reduced, demonstrated as resistance to nondepolarizers documented in burns, denervation, and immobilization. [1](#) This resistance may be related to decreased affinity of the receptor to nondepolarizers and to the upregulation of receptors. Indeed, recent data suggest that some nondepolarizers may also cause a partial agonist response in immature receptors, explaining the decreased potency. [4](#) The altered sensitivities for cholinergic ligands may also result from changes in composition of the lipid membrane surrounding the receptor that is known to occur with some pathologic states. [30](#)

The sensitivity to muscle relaxants may occur in only certain parts of the body or certain muscles if only some muscles are affected by the diminution of nerve activity (e.g., after a stroke). The sensitivity to relaxants can begin to change between 24 and 72 hours after an injury or hospitalization. The most serious side effect with the use of succinylcholine in the presence of upregulated receptors in one or more muscle is hyperkalemia. [1](#) In these subjects, the receptors can be scattered over a large surface of the muscle. As indicated previously, the immature receptors are especially sensitive to succinylcholine. The channels opened by the agonist allow potassium to escape from the muscle and enter the blood. If a large part of the muscle surface consists of upregulated (immature) receptor-channels, each of which stays open for a longer time, the amount of potassium that moves from muscle to blood can be very large. The resulting hyperkalemia can cause dangerous disturbances in cardiac rhythm, including ventricular fibrillation. Moreover, it is difficult to prevent the hyperkalemia by the prior administration of nondepolarizers because extrajunctional receptors are not very sensitive to block by nondepolarizing relaxants. Larger than normal doses of nondepolarizers may attenuate the increase in blood potassium but will not completely prevent it.

Myopathy of Critical Illness

Critical illness (also see Chs. [12](#) and [72](#)) such as sepsis, trauma, and burns induce functional and pharmacologic aberrations at the skeletal muscle, similar to that seen with upper or lower motor neuron injuries. As indicated previously, the aberrant *pharmacologic* responses consist of a hyperkalemic response to succinylcholine and resistance to nondepolarizers. The important *functional* change is muscle weakness resulting in hypoventilation, dependence on respirators, and decreased mobilization. [43, 44](#) The pathognomic biochemical feature in all of these conditions is the upregulation of acetylcholine receptors with expression of immature (γ-subunit) isoform of receptors. [40](#)

The immature, as compared with the mature, isoform has different electrophysiologic characteristics, including prolonged open-channel time. In some clinical conditions, the presence of a prolonged open-channel time (due to congenital mutations in the receptor) is associated with muscle weakness. [14, 45](#) In the pathologic state of burns, sepsis, and trauma, in which muscle weakness is a concomitant finding, the expression of the immature isoform at the perijunctional membrane may have a role in muscle weakness. Additionally, the expression of the immature isoform may decrease the number of mature isoforms, a situation akin to myasthenia gravis, in which the mature receptor number at the junction is decreased. Furthermore, in mice, deletion of the mature ε-subunit-containing receptors causes muscle weakness despite the expression of immature receptors at the postjunctional membrane. [46](#) In all of these conditions in which the immature isoform is expressed, signaling via receptor tyrosine kinases or via growth factors seems to be impaired. [47, 48](#) Additional compounding effects related to deficient growth factor signaling include apoptosis in muscle with loss of contractile elements. Apoptosis, occurring in cardiac muscle, contributes significantly to myocardial dysfunction. [49](#) The loss of muscle mass, due to apoptosis, may compound the skeletal muscle weakness related to immature receptor expression. [50](#) Signaling via receptor kinases and its effects on acetylcholine expression and apoptosis seem to be an intense area of research by many groups. Correction of the altered signaling mechanism may therefore reverse the expression of the immature to mature isoform, attenuate the apoptosis in muscle, and correct the muscle weakness associated with critical illness.

Prejunctional Receptors

Compared with the postjunctional area, the prejunctional nerve ending is less well understood. Many drugs, with an abundance of potential targets for drug action, can affect the capacity of the nerve terminal to carry out its functions. The trophic function to maintain the nerve-muscle contact involves release and replenishment of acetylcholine together with trophic factors that require signaling through many receptors, of which the prejunctional nicotinic receptor is just one. Prejunctional or nerve terminal-associated cholinergic receptors have been demonstrated pharmacologically, but their form and functions are not well understood.

Previously, it was observed that succinylcholine produces fasciculations and that these are prevented by nondepolarizing relaxants. Since a fasciculation is, by definition, the simultaneous contraction of the multitude of muscle cells in a single motor unit and since only the nerve can synchronize all the muscles in its motor unit, it was apparent that succinylcholine must also act on nerve endings. Also, since nondepolarizing relaxants prevent fasciculation, it was concluded that they acted on the same prejunctional receptor. Since then it has been shown many times that very small doses of cholinergic agonists (e.g., succinylcholine) and antagonists (e.g., curare) affect nicotinic receptors on the nerve ending, the former by depolarizing the ending and sometimes inducing repetitive firing of the nerve, and the latter by preventing the action of agonists. **3**

Another clue to differences was the finding that although both pre- and postjunctional nicotinic receptors bind α -bungarotoxin, prejunctional binding was reversible whereas postjunctional binding was not. Additional clues were found in the many demonstrations of quantitative differences in the reaction of pre- and postjunctional nicotinic receptors to cholinergic agonists and antagonists. **51** For instance, it was known that tubocurarine and hexamethonium bind very poorly to the recognition sites of ganglionic nicotinic cholinergic receptors and were not competitive antagonists of acetylcholine at this site. Instead, they blocked the opened channels of these receptors and owed their ability to block ganglionic transmission to this property. The functional characteristics of the receptor channels may also be different. For example, the depolarization of motor nerve endings initiated by administration of acetylcholine can be prevented by tetrodotoxin, a specific blocker of sodium flux with no effect on the end plate.

Specific information on the molecular organization of the neuronal nicotinic receptors on motoneuron terminal is lacking, but work on other parts of the nervous system (e.g., the brain and ganglia) indicate that they are structurally quite different from those found on the postjunctional muscle membrane. **52, 53** Some of the subunit composition is similar, but other subunits do not resemble that of the postjunctional receptor. At least ten different gene products ($\alpha 2$ to $\alpha 8$ and $\beta 2$ to $\beta 4$) are thought to contribute nicotinic receptors expressed in neurons. Most strikingly, nervous tissue does not contain genes for γ -, δ - or ϵ -receptor subunits; it contains only the genes for α - and β -subunits. Furthermore, the α - and β -subunit genes in nerve and muscle are not exactly the same; they are variants. Muscle contains only one gene for each subunit, which are now termed $\alpha 1$ and $\beta 1$ -subunit. By contrast, nervous tissue contains neither of these but rather contains a number of related genes termed $\alpha 2$ through $\alpha 8$. To emphasize the distinction between neural and muscle nicotinic receptors, the former are termed Nn and the latter Nm. With so many different subunits available, there are many possible combinations, and it is not known which combinations are found in motor nerves. Their physiologic roles have also not been completely characterized.

The nicotinic receptor in the nerve ending of the neuromuscular junction may serve the function of regulator of transmitter release, as shown in other parts of the nervous system. The nicotinic receptor on the junctional surface of the nerve senses transmitter in the cleft and, by a positive feedback system, causes the release of more transmitter. In other parts of the nervous system, this positive feedback is complemented by a negative one, which senses when the concentration of transmitter in the synaptic cleft has increased appropriately and shuts down the release system. Indirect evidence suggests that these receptors are muscarinic cholinergic receptors. Convincing data that motor nerve endings contain muscarinic receptors or a negative feedback system are not yet available for the motor neuron. The nerve ending is also known to bear several other receptors (e.g., opioid, adrenergic, dopamine, purine, and adenosine receptors, and receptors for endogenous hormones, neuropeptides, and a variety of proteins). The physiologic roles of these or of the effects of anesthetics on them are unknown.

The motor nerves take up choline, synthesize acetylcholine, store it in vesicles, and move the vesicles into position to be released by a nerve action potential, a series of processes known collectively as *mobilization*. Muscle relaxants to a greater or lesser extent, however, seem to influence this mobilization process. Tubocurarine and related muscle relaxants have a profound effect in decreasing the nerve's capacity to prepare more acetylcholine for release. Tubocurarine has no direct effect on the release process for acetylcholine; the amount of transmitter released is controlled by the availability of releasable acetylcholine and the amount of calcium that enters the nerve. Although it has frequently been observed that nondepolarizing relaxants do not diminish the transmitter released by a single nerve impulse or the first in a high-frequency train of impulses, they sharply decrease the release triggered by subsequent nerve pulses in the train. The most common manifestation of this is the so-called *tetanic fade* commonly seen after a nondepolarizing relaxant is administered. This effect is thought to be due to inhibition of the process that replenishes releasable acetylcholine. **3**

ANTAGONISM OF NEUROMUSCULAR BLOCK

Mechanism of Antagonism

The nondepolarizing relaxants block (also see [Ch. 12](#)) neuromuscular transmission predominantly by competitive antagonism of acetylcholine at the postjunctional receptor. Therefore, the most straightforward way to overcome their effects is to increase the competitive position of acetylcholine. Two factors are important, the first of which is the concentration of acetylcholine. Increasing the number of molecules of acetylcholine in the junctional cleft changes the agonist/antagonist ratio and increases the probability that agonist molecules will occupy the recognition sites of the receptor. It also increases the probability that an unoccupied receptor will become occupied. It should be recalled that normally only about 500,000 of the 5 million available receptors are activated by a single nerve impulse, and so a large number of receptors are in “reserve” and could be occupied by an agonist. The second factor important to the competitive position of acetylcholine is the length of time acetylcholine is in the cleft. Acetylcholine must wait for the antagonist to dissociate spontaneously before it can compete for the freed site. The nondepolarizing relaxants bind to the receptor for slightly less than 1 millisecond, which is longer than the normal lifetime of acetylcholine. To put it another way, the destruction of acetylcholine normally takes place so quickly that most of it is destroyed before any significant number of antagonist molecules have dissociated from the receptor. Prolonging the time during which acetylcholine is in the junction allows time for the available acetylcholine to bind to receptor, when the antagonist dissociates from the receptors.

Classes of Drugs Used

Two classes of drugs, potassium channel-blocking drugs and acetylcholinesterase inhibitors, are used clinically to reverse non-depolarizer-induced paralysis. The best known of the potassium blocking drugs is 4-aminopyridine. Its actions are predominantly prejunctional; it impedes the efflux of potassium from the nerve ending. Since the efflux of potassium is the event that normally ends the action potential of the nerve ending, this action prolongs the depolarization of the nerve. Because the flux of calcium into the nerve continues for as long as the depolarization lasts, drugs of this class indirectly increase the flux of calcium into the nerve ending. Therefore, the nerve releases more acetylcholine and for a longer time than usual, conditions described previously, which are effective in antagonizing nondepolarizing relaxants. Because they act prejunctionally, these drugs can antagonize a block produced by certain antibiotics that act on the nerve ending, notably the polymyxins. Although 4-aminopyridine and drugs like it can be used clinically, their use is severely restricted because they are not specific. They affect the release of transmitters by all nerve endings, including motor nerves, autonomic nerves, and central nervous system components. Accordingly, their use is accompanied by a variety of undesirable effects, and in practice they are used only in special circumstances. A most serious side effect of potassium channel blockers is seizures.

The more commonly used antagonists of neuromuscular block (e.g., neostigmine, pyridostigmine, and edrophonium) all inhibit acetylcholinesterase by mechanisms that are similar but not identical. [54](#) Neostigmine and pyridostigmine are attracted by an electrostatic interaction between the positively charged nitrogen in the molecules and the negatively charged catalytic site of the enzyme. This produces a carbamylated enzyme, which is not capable of further action (i.e., the catalytic site is blocked and the enzyme is inhibited). Edrophonium has neither an ester nor a carbamate group, but is attracted and bound to the catalytic site of the enzyme by the electrostatic attraction between the positively charged nitrogen in the drug and the negatively charged acetylcholinesterase site of the enzyme. Edrophonium also seems to have prejunctional effects, enhancing the release of acetylcholine from the nerve terminal. This effect is, therefore, useful when deep neuromuscular block needs reversal. Of the three commonly used anticholinesterases, edrophonium shows by far the greatest selectivity between acetylcholinesterase and butyrylcholinesterase, the serum esterase that hydrolyzes succinylcholine and mivacurium. It greatly favors the former enzyme and therefore would seem to be the most desirable agent to reverse mivacurium. However, assuming that the patient has normal serum esterase, pharmacokinetic factors are the principal determinants of the duration of blockade, and the activity of serum esterase or the lack of it plays only a minor role in the recovery. Therefore, there is little reason to prefer one or another reversal drug on these grounds.

The cholinesterase inhibitors do not only act preferentially at the neuromuscular junction but also act at other synapses that use the same transmitter, including muscarinic receptors. Thus, it is desirable to administer

an atropine-like drug along with the cholinesterase inhibitor to counter the effects of the acetylcholine that accumulates in the muscarinic synapses of the gut, bronchi, and cardiovascular system. These three anticholinesterase inhibitors do not affect synapses in the central nervous system because all are quaternary ammonium ions, which do not easily penetrate the blood-brain barrier. Therefore, a quaternary ammonium derivative of atropine, such as glycopyrrolate, which does diffuse through the blood-brain barrier, frequently is used to limit the anticholinergic effects to the periphery. Other cholinesterase inhibitors, notably physostigmine and tacrine, are not quaternary ammonium compounds, and they have profound effects in the central nervous system. These may be antagonized by atropine but not by its quaternary ammonium analogue derivatives. Unlike the other cholinesterase inhibitors, physostigmine and tacrine are also potent inhibitors of the enzyme phosphodiesterase, which plays an important role in the regulation of transmitter release at many synapses in the central nervous system. This action may be related to the reported efficacy of these two in the treatment of Alzheimer's dementia.

Cholinesterase inhibitors also have actions at the postjunctional membrane, independent of its effects on the enzyme. Several of these compounds contain methyl groups on a positively charged nitrogen, and they can act as agonists on the receptor channels, initiating ion flow and enhancing neuromuscular transmission. It was noted long ago that neostigmine, physostigmine, and certain organophosphates can increase the frequency of MEPPs and increase the quantal content of end plate potentials, but the importance of the increased transmitter release to reversal of neuromuscular blockade is not known. Also, continuous exposure to the carbamate- or organophosphate-containing inhibitors causes degeneration of pre- and postjunctional structures, apparently because these structures accumulate toxic amounts of calcium. The neural actions of these drugs are prevented by calcium channel blockers such as verapamil. All the drugs of this class also act in or on receptors to influence the kinetics of the open-close cycle and to block the ion channel. [37](#), [38](#) The clinical significance of the drugs on reversal of nondepolarizers is not known.

SUMMARY

The neuromuscular junction provides a rich array of receptors and substrates for drug action. Several drugs used clinically have multiple sites of action. The muscle relaxants are not exceptions to the rule that most drugs have more than one site or mechanism of action. The major actions seem to occur by the mechanisms and at the sites described for decades, namely, agonistic and antagonistic actions at postjunctional receptors for depolarizing and nondepolarizing relaxants, respectively. This description of neuromuscular drug action is a simplistic one. Neuromuscular transmission is impeded by nondepolarizers because they prevent access of acetylcholine to its recognition site on the postjunctional receptor. If the concentration of nondepolarizer is increased, another, noncompetitive action, namely block of the ion channel, is superimposed. The paralysis is also potentiated by the prejunctional actions of the relaxant preventing the release of acetylcholine. The latter can be documented as fade that occurs with increased frequency of stimulation. Therefore, a more accurate description of the relaxant effects recognizes that the neuromuscular junction is a complex system and a dynamic one, in which the phenomena produced by drugs are composites of actions that vary with drug, dose, activity in the junction and muscle, time after administration, the presence of anesthetics or other drugs, and the age and condition of the patient. Inhibition of the postjunctional acetylcholinesterase by anticholinesterases increases concentration of acetylcholine, which can compete and displace the nondepolarizerreversing paralysis. These anticholinesterases also have other effects, including those on nerve terminals and on the receptor, by an allosteric mechanism.

Depolarizing compounds initially react with the acetylcholine recognition site and, like the transmitter, open ion channels and depolarize the end plate membrane. Unlike the transmitter, they are not subject to hydrolysis by acetylcholinesterase and so remain in the junction. Soon after administration of the drug, some receptors are desensitized and, although occupied by an agonist, do not open to allow current to flow to depolarize the area. If the depolarizing relaxant is applied in high concentration and allowed to remain at the junction for a long time, other effects occur. These include entry of the drug into the channel to obstruct it or to pass through it into the cytoplasm. Depolarizing relaxants also have effects on prejunctional structures, and the combination of pre- and postjunctional effects plus secondary ones on muscle and nerve homeostasis results in the complicated phenomenon known as phase II blockade.

Intense research in the area of neuromuscular transmission continues at a rapid pace. The newer observations on receptors, ion channels, membranes, and prejunctional functions reveal a much broader range of sites and mechanisms of action for both agonists and antagonists and thereby allow a more

complete understanding. In recognizing these sites and mechanisms we begin to bring our theoretical knowledge closer to explaining the phenomena observed when these drugs are administered to living humans. Most of the recent work seems to be focused on the postjunctional membrane and the control of acetylcholine receptor expression in normal and diseased states. The presence or absence of the mature and immature isoform seem to complicate matters further. In certain pathologic states (e.g., sepsis, burns, immobilization, and chronic use of relaxants), upregulation of acetylcholine receptors occurs, usually with expression of the immature isoform. The altered functional and pharmacologic characteristics of these receptors results in increased sensitivity with hyperkalemia to succinylcholine and resistance to nondepolarizers. An area of increasing attention is the control of the expression of mature versus immature receptors and the role of the immature isoform of the receptor in the muscle weakness associated with the critical illnesses enumerated previously. The immature isoform expression is probably related to aberrant growth factor signaling, which may also cause apoptosis in muscle. Loss of muscle mass due to apoptosis may contribute to the muscle weakness of critical illness. In the future, it may be possible to manipulate the signaling mechanism to alter the expression of the receptor isoforms, attenuate apoptosis, and possibly improve muscle functions. Alternately, these could be achieved by gene therapy.