

serum magnesium (0.4 mmol/l; normal range 0.7–1.0 mmol/l) calcium gluconate was discontinued and magnesium sulphate was administered.

The tetany responded immediately but his condition gradually worsened and he died. The diagnosis of Hodgkin's lymphoma was confirmed at autopsy. The hypomagnesaemia was due to renal tubular damage from aminoglycosides.³

Since magnesium deficiency impairs secretion of parathyroid hormone and may render bone and kidney resistant to the effect of the hormone, hypocalcaemia can be reversed only by administration of magnesium.⁴

The syndrome may occur during prolonged courses of aminoglycosides and monitoring of serum potassium and serum calcium as well as serum magnesium concentration is therefore recommended for such patients.

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References

1. Wilkinson, R., Lucas, G.L., Heath, D.A., Franklin, I.M. & Boughtan, B.J. Hypomagnesaemic tetany associated with prolonged treatment with aminoglycosides. *Br Med J* 1986, **292**: 818.
2. Bonadonna, G., Fossati, V. & De Lena, M. Cyclic delivery of MOPP and ABVD combinations in stage IV Hodgkin's disease: rationale background studies and recent results. *Cancer Treatment Reports* 1982, **66**: 881.
3. Freedman, D.B., Shannan, M., Dandona, P., Prentice, H.G. & Hoffbrand, A.V. Hypoparathyroidism and hypocalcaemia during treatment for acute leukaemia. *Br Med J* 1982, **284**: 700.

4. Rude, R.K., Oldham, S.B., Sharp, C.F. & Singer, F.R. Parathyroid hormone secretion in magnesium deficiency. *J Clin Endocrinol Metab* 1978, **47**: 800.

Transfer from recovery room to ward

Sir,

From an anaesthetic point of view, a patient can be discharged from the recovery room (a) when he is able to maintain adequate alveolar ventilation and can clear his airway; (b) he is awake, alert, well orientated in space and time and can make his wants and needs known, and (c) if he is able to maintain adequate tissue perfusion, without continuous monitoring and support of his cardio-vascular system. Patients with unstable cardio-vascular systems should not be moved, unless they are well stabilized.

From the surgical point of view, if the patient is not expected to need close surgical surveillance he can be transferred to his ward. A trained nurse preferably should accompany the patient whenever necessary.

The author's (Salim) recovery score (Table I) assesses three physical signs, i.e. 'ABC of recovery' – Airways, Behaviour, Consciousness. A score of eight is the minimum for discharge from the recovery room in most instances.

We assessed this ABC score in more than 2000 patients aged one to 80 years to judge its effectiveness. We found that this score is effective for assessing recovering patients and sending them to the wards.

It is a great help to trainee doctors and students. We have now made a printed chart in our recovery room for guidance of trainees, doctors and nurses.

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References

1. Anis & Salim, M. In: *Anaesthesia and Patient Care*. Army Press, 6 Zafar Akbar Road, Lalazar Rawalpindi, Pakistan, 1983, p 1422.
2. Salim, M. Postanaesthetic recovery. *Pakistan Medical Journal* 1987, 46–50.

Table I Postanaesthetic recovery score

Physical signs	Salim's ABC recovery score			
	3	2	1	0
Airways	Patient can cough or cry	Maintains clear airway without holding the jaw	Holding of jaw needed	Holding of jaw and other measures taken to maintain airways
Behaviour	Patient can lift the head	Can open the eyes and show his tongue	Some non-purposeful movements	No movements at all
Consciousness	Fully awake, can talk, well oriented	Awake but needs support	Responds to stimuli only	No response