

WELLMAN, I. VICTORIA; KABLE, VERA N., AND LIVINGSTONE, HUBERTA M.: *Vinethene for Dental Anesthesia*. J. Am. Dent. A. 30: 1883-1888 (Dec. 1) 1943.

"It is the purpose of this communication to present our results with vinethene anesthesia in a series of 312 dental patients. Operations consisted mainly of simple dental extractions with some instances of extraction involving impacted teeth, removal of dental cysts or alveolectomy. . . . The physical state was good in 254 patients, fair in forty-seven and poor in eleven. . . . All of the patients had received no fluid or food by mouth for at least six hours before operation. The bladder and rectum had been recently emptied. A physical examination, including at least an examination of the heart and lungs and a urinalysis, was made before anesthetization. Many of the patients had been given more extensive physical examination in the department of internal medicine or of pediatrics. Premedication was not employed in most patients, and was not found to be essential in most instances. . . . In a few apprehensive persons, calcium pentobarbital gm. 0.09 to 0.27, dissolved in from 30 to 50 cc. of water, was administered per rectum. In occasional instances, adults received morphine sulfate gm. 0.010 to 0.015 (h) preferably one hour before anesthesia. . . . Open drop ether masks were employed. . . .

"The eyes were protected with a wet cotton pad. Vinethene was dropped from the original container onto the lower two-thirds of the mask, with the bottle near the mask and moving from one area to another to permit rapid vaporization. It was found to be absolutely necessary that a large amount of air be available to the patient at all times. After the stage of surgical anesthesia was reached, the mask was

moved until it rested only over the nose, the anesthetist making sure that no pressure was exerted against the external nares. The dropping of vinethene was continued throughout the surgical procedure. . . . The upper air passages were kept patent and free from mucus or blood, and suction was employed whenever indicated. In most instances, the mouth prop was not inserted until consciousness was lost, and then a pack was placed to prevent aspiration. . . . Vinethene administration should be started slowly and the rate of dropping rather rapidly increased to a maintenance rate of 30 to 60 drops per minute. . . . The average time for loss of consciousness was 1.37 minutes. . . . The least vinethene required for loss of consciousness was 2 cc.; the maximum amount, 25 cc. An average of 7 cc. was required for loss of consciousness. . . .

"Overdosage was not observed in the 312 dental patients and occurred very rarely in our experience in a total of 4,187 vinethene administrations. It is diagnosed by the abolition of upper intercostal activity, and only depressed, irregular, jerky, spasmodic contractions of the lower intercostal muscles and diaphragm are present. Cyanosis and respiratory arrest may quickly follow. Muscular twitching has been observed in a few instances of overdosage. . . . One of the striking advantages of vinethene anesthesia is the promptness with which consciousness returns, and the minimum of post-operative disturbance. We observed nausea and vomiting during recovery in only eight, or 2.6 per cent, of the dental patients. . . . The contraindications for vinethene thus far more generally agreed upon are particularly known or suspected hepatic damage, operations lasting over thirty minutes, the presence of a flame or sparking device; anuria, uremia or marked disease of the kidneys; paralysis of the vocal

cords; ankylosis of the jaws; goiter; extensive disease of the lungs; diabetes; cyanosis; intestinal obstruction, and advanced debility." 39 references.

J. C. M. C.

PRICE, H. J.: *The Relief of Acute Pleuritic Pain by Intercostal Nerve Block*. J. A. M. A. 123: 628-629 (Nov. 6) 1943.

"My purpose in this report is to describe a procedure of relieving pleural pain by inducing intercostal nerve block with procaine hydrochloride. This method is simple and effective, often producing permanent relief of the pleural pain associated with pneumonia. It allows relatively free motion of the thoracic wall and so favors adequate aeration of the lungs, affording protection against the complication of atelectasis. Drainage of the involved area of the lung is promoted, for coughing is rendered nearly painless. . . . The nerves to be injected are those corresponding to the intercostal spaces over which definite tenderness can be elicited by slight pressure. The injection is made most conveniently in the posterior axillary line or anterior to this. However, in instances in which the hyperesthesia is located more posteriorly, injection can be made in the midscapular line. A procaine hydrochloride wheal is first made in the overlying skin. A 20 to 21 gage needle is then introduced through the anesthetized area of skin until contact is made with the outer border of the rib immediately above the selected space. The periosteum is anesthetized with a few minims of procaine hydrochloride, after which the needle point is carried down to the inferior margin of the rib, where it falls into the groove occupied by the intercostal nerve and vessels. At this point traction is exerted on the plunger until the operator is certain that the needle has not entered a vessel. If no blood is drawn, the nerve

is then infiltrated with 2 cc. of a 1 per cent solution of procaine hydrochloride. . . . In a series of 14 consecutive cases, severe pleural pain was relieved effectively by intercostal nerve block. The resultant improvement in the general condition of the patients was striking. Anxiety disappeared, and most patients fell asleep shortly after the procedure was completed. For some this was the first rest in many hours." 3 references.

J. C. M.

IGLAUER, SAMUEL: *Bronchoscopy as Diagnostic and Therapeutic Procedure*. Nebraska M. J. 28: 340-341 (Nov.) 1943.

"Atelectasis may occur in a segment of a lobe, in a single lobe, or as a massive involvement of an entire lung. In this paper only post-operative atelectasis will be considered. It occurs most frequently after high laparotomy, but may follow operations on any part of the body. The predisposing factors are aspiration and retention of mucus and saliva during the operation. After laparotomy, splinting of the abdominal muscles from pain tympanites, trapping of air under the diaphragm, and tight bandages all interfere with the diaphragm. As a result the secretion within the bronchi can not be expelled especially if the patient refrains from coughing or if the cough reflex has become abolished from the administration of morphine. Massive collapse is as common after spinal or local anesthesia as after inhalation anesthesia. The diagnosis of this condition is confirmed by the roentgenogram. The diaphragm on the affected side is elevated and is associated with narrowing of the intercostal spaces. The heart and mediastinal structures are shifted toward the opaque collapsed lung. . . . Bronchoscopic treatment should most frequently begin in the operating room. When the anesthetist states that the