

CORRESPONDENCE

To the Editor of Anesthesiology:

I desire to bring to your attention the problem of pentothal as an inducing agent for general anesthesia (nitrous oxide-oxygen and ether).

In the May 1946 issue of ANESTHESIOLOGY, under Abstracts, page 350, line 17, Dr. J. P. Hand, Jr., states that "Pentothal as an induction agent for inhalation anesthesia reduces the time required for induction of the patient to the surgical level. . . ." I have witnessed a tremendous number of pentothal inductions given by doctors and nurses and have arrived at the conclusion that pentothal delays the time required for induction of the patient to the required surgical level. In estimating the time element to bring a patient to a surgical level of anesthesia, I am aware of the fact that nervous, apprehensive, and alcoholic types of patients will in all probability have an excitement stage which will interfere with induction of good anesthesia. In these cases small amounts of pentothal are indicated. Large amounts will depress respiration, decrease the minute volume exchange, and thereby prolong the time required to obtain the desired surgical level. In properly premedicated patients, pentothal is actually unnecessary.

From a comparative standpoint the time element depends on the patient's ability to take the inhalation mixture, which in turn really depends on the skill of the anesthetist in administering the mixture to the patient.

During pentothal induction, if an airway is inserted too early (and this happens very frequently for one reason or another), the production greatly disturbs the patient and the anesthetist. If patients are given a sufficient amount of pentothal to obtund reflexes, respiratory depression sets in and prolongation of the time to reach a desired surgical level ensues.

Pentothal given rapidly, either alone, or followed by curare in doses sufficient to permit intubation, may permit early insertion of an endotracheal tube. This advantage is off-set by the fact that when the switch is made to gas-oxygen ether, or ether-oxygen for maintenance, it is difficult to tell for a long period when the pentothal effect has been taken over by the ether effect. One must be an expert to recognize the transitional point.

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To the Editor:

In the May Journal, E. A. Tyler criticizes A. L. Barnach for some statements made by the latter about nitrous oxid and mentions "a few cases killed by" it. I can assure him that until comparatively recent years such deaths were not "few" but so many that nitrous oxid had the highest death rate of any anesthetic. So many deaths that many prominent surgeons condemned it and refused to permit it to be given to their patients.

Among them were the late G. F. Baldwin of Columbus, Ohio, and G. C. Mosher of Kansas City, Mo. They gathered reports of many deaths and so interested me that I obtained many additional reports until there were several hundred, all in the United States. Among others interested were anesthetists like G. T. Gwathmey, who

reported 30 cases of which he knew, C. K. Teter reported 26 of which 13 were in Cleveland, and A. H. Miller of Providence reported 18. In Akron I knew of 8, two of them occurring in ten days under the administration of our most expert nitrous oxid administrator at that time.

Some surgeons and anesthetists endeavored to conceal their deaths; others frankly admitted them. Nitrous oxid enthusiasts in papers read at meetings usually started out by describing how much superior it was to the disagreeable experience of "taking" ether. At one meeting of the Interstate Association of Anesthetists (now the International) I criticized such statements and told the man who made them that they should cease living in glass houses after the awful death rate nitrous oxid had. One member who is now one of our foremost