leave a fair amount of extra ventilating capacity in reserve for lungs with low compliance. Analysis of arterial blood samples taken 10 minutes after the start of bronchoscopy gave an average $P_{CO_2}$ of 29 torr, which bears out this contention.

We believe that using this technique, anesthesia for bronchoscopy can be made simpler without increasing the risks. Prior to the use of the nitrous oxide–oxygen mixtures, we were intermittently injecting barbiturates intravenously as a method of ensuring hypnosis while oxygen was being jetted into the bronchoscope. Recovery from barbiturate anesthesia is likely to be more prolonged than recovery from nitrous oxide anesthesia.

There is a possibility that inhalation of sufficient nitrous oxide by the bronchoscopist could cause impairment of his judgement and abilities and endanger the patient. In our experience with 20 bronchoscopies carried out in this manner, no surgeon has experienced any episode of euphoria. The use of visors and the dilution effect of the operating room air probably reduces the concentration of nitrous oxide inhaled by the surgeon to a minimum. Since nitrous oxide is relatively innocuous and the procedures are usually of short duration, we consider the hazard from nitrous oxide inhalation by both bronchoscopists and anesthesiologists to be negligible. The use of 70 per cent nitrous oxide and 30 per cent oxygen for the majority of cases is satisfactory and can be expected to increase $P_{O_2}$ during bronchoscopy.

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REFERENCES

A Simple Technique for Inserting Catheters Intravenously in Difficult Anatomic Areas

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The percutaneous insertion of catheters for intravenous infusion of fluids and drugs is widespread. Inserting the catheter into an external jugular vein, a femoral vein, or a cephalic vein at the wrist may be difficult due to anatomic interference of surrounding structures or patient position.

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Figure 1 illustrates a technique which simplifies the insertion of catheters into veins located in difficult anatomic areas. The needle with the external catheter is pulled as a unit halfway from the protective cover and then bent to an angle of 20–40 degrees. The angle allows the unit to be manipulated with ease and thus avoid surrounding anatomic interferences such as the ear or jaw in the case of a straight approach to the external jugular vein. The flexible needles and pliable cathe-
Thiamylal Anaphylaxis

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The following report concerns a patient who developed hives, bronchial spasm, facial edema, and shock shortly after induction of anesthesia. Fortunately, prompt treatment reversed the ominous chain of events, and he had an uneventful recovery. Skin testing with thiamylal (Surital), d-tubocurarine (Tubocurarine chloride), and succinylcholine (Quelicin), the drugs used prior to collapse, revealed that it was thiamylal which caused the reaction.

REPORT OF A CASE

The patient, a 44-year-old electrician, was first admitted to the Little Rock Veterans Administration Hospital in October 1972, for cervical diskectomy and fusion. In 1964 he had sustained an injury to his neck, with resultant pain and weakness in his upper extremities. Cervical diskectomy had been performed in 1964 and again in 1965; however, his symptoms persisted. Details of the anesthetics are unknown. He also had a bilateral inguinal herniorrhaphy in 1970, excision of an eyelid lesion in April 1972, and a right inguinal herniorrhaphy in

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