with clots poured out of the patient's mouth. In spite of vigorous aspiration of the pharynx alternating with attempts to inflate the lungs with oxygen by mask, a long but undetermined interval occurred before the pharynx was clear enough for visualization of the glottic opening. During this interval the blood pressure which had been stable at 90/70 became unobtainable, and the pulse became imperceptible. A large blood clot which was impacted in the glottis was removed with a clamp, and an endotracheal tube was passed, and immediate inflation of the lungs with oxygen restored the blood pressure to 130/75 and the quality of the pulse improved markedly. The operation was completed rapidly and aspiration bronchoscopy at the termination of anesthesia produced a moderate amount of bloody fluid from the bronchial tree.

Consciousness was regained within ten minutes after termination of anesthesia and the vital signs remained stable. There were no immediate postoperative complications; however, ascites occurred on the eighth postoperative day. The patient gradually became somnolent, lapsed into coma, and died on the fortieth postoperative day. Pertinent findings at autopsy were hemachromatosis with marked portal cirrhosis and esophageal varices.

It is probable that rupture of the esophageal varices occurred during the period of respiratory obstruction, and the brief episode of coughing following the insertion of the oropharyngeal airway. A sudden increase in intra-abdominal pressure is recognized as a factor precipitating the rupture of esophageal varices (Spellberg, M.: Diseases of the Liver. New York, Grune & Stratton, Inc., 1954). For this reason avoidance of increase in intra-abdominal pressure during anesthesia in patients with known esophageal varices is of paramount importance.

CORRESPONDENCE

WILLIAM THOMAS GREEN MORTON

To the Editor.—“Vanity, all is vanity...”

“Dentistry” enjoys basking in the reflected honor and prestige accorded William Thomas Green Morton, “whose labors in introducing the anesthetic process into surgical operations have given him an eminent place among the benefactors of the human race.”

Dr. Betcher’s and your attention is respectfully called to an error in reporting by the New York Tribune, July 17, 1868. (Betcher, A. M.: A Ride Through Central Park [Editorial], Anesthesiology 18: 785 [Sept.–Oct.] 1957.)

ORLAN K. BULLARD, D.D.S.
San Diego, California

To the Editor.—I am in receipt of Dr. Bullard’s recent letter in which he calls attention to an error in reporting by the New York Tribune, July 17, 1868. I assume he refers to the final sentence in which Morton is called a Doctor of Medicine.

It is true that at the time of his demonstration at the Massachusetts General Hospital, October 16, 1846, he was referred to in the Boston Daily Journal of the next day as, Dr. Morton, Dentist. Also, in Jacob Bigelow’s letter to Francis Boott of London of November 28, 1846, he stated, “The inventor is Dr. Morton, a dentist of this city. . . .” In this same year, Morton issued a circular to “Surgeons and Physicians” announcing his competency in administering “his compound to patients who are to have surgical operations performed,” and signed it W. T. G. Morton, Dentist.

However, if we search further, we discover that by 1850, he had published two papers with a different signature: “Comparative Value of Sulphuric Ether and Chloroform.”
CORRESPONDENCE


Something must have happened between 1846 and 1850 to permit him to place an "M.D." after his name. It is known that Morton, perhaps through Jackson's influence, wanted to become a physician and in 1844 was attending medical lectures at Harvard in addition to his professional activities as a dentist. He never completed the course at Harvard, however.

The answer can be found in the following quotation from H. R. Raper, who will never be called a Mortonophile:

"Irate dentists have on occasion hotly accused the medical profession of kidnapping Morton because of his anesthesia fame, but this seems rather foolish. What happened was a natural development under the circumstances. The Washington University (name later changed to the Baltimore College of Physicians and Surgeons) undoubtedly conferred the M.D. degree on Morton in 1849 because they thought he deserved the honor; and once he received it he became identified with Medicine." (Raper, H. R.: Man Against Pain: The Epic of Anesthesia. New York, Prentice Hall, Inc., 1945, p. 147.)

It appears, therefore, that the New York Tribune of July 17, 1868, was accurate in its reporting.

ALBERT M. BETCHER, M.D.
New York, New York

PROMETHAZINE

To the Editor.—We read with great interest Dr. Eckenhoff's paper (Anesthesiology 18: 703 [Sept.-Oct.] 1957) on promethazine.

We were, and still are, of the opinion that when used in conjunction with meperidine and hyoscine (or perhaps atropine), promethazine produces excellent preoperative sedation.

We are surprised to hear about the restlessness and can only surmise that the "atmosphere" in Pennsylvania must be a little "unsettling." Our patients have not only appeared quiet but have also shown a very pleasing stability of vital signs under anesthesia.

We would like to suggest that, since Dr. Eckenhoff himself states "respiratory studies under such circumstances (restlessness) may be misleading" and "if a drug is usually sedative, it is probably unfair to describe its effects on respiration if studies have been made in patients or subjects exhibiting restlessness," we can only assume that no valid information on the respiratory effects of the drug has been presented.

Dr. Eckenhoff describes only three side effects yet goes on to say that the use of the drug is questionable because of them. This is ridiculous. Two of them, the respiratory effect and restlessness are in doubt, and the third is actually of minimal consequence since morphine also produces postural hypotension—as is quoted in the article.

To condemn a good drug on such insufficient evidence is unwarrantable. There are other good drugs, which have worse side effects, which are more questionable, yet they stay with us. While we hesitate to use these except when we feel we must (where "must" may be a self-delusion), we cannot yet feel this way about promethazine.

(The three side effects mentioned in this letter appear to be the only ones investigated. We are, of course, looking forward to information on the respiratory effect of promethazine-meperidine (even ± allyl derivatives) and also on the presence or absence of potentiation.)

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