NEEDLE STORAGE RACK FOR NERVE BLOCK CLINIC

Facility, sterility, and accessibility of nerve block needles are a prerequisite for any Nerve Block Service. A wide selection of needles also should be readily available. The photograph (fig. 1) shows a simple storage rack that has been devised to fulfill these requirements.

The needle rack * is constructed of stainless steel and has 2 tiers of grooved cut-outs to fit standard sized Pyrex test tubes. These tiers are fixed at an angle of 45 degrees to prevent slipping out of the needle-containing test tubes during handling. Over-all dimensions of the rack are 12" by 6" by 13", which accommodates 30 test tubes. These dimensions may be varied to suit individual requirements of number of needles and storage sites. Each test tube is fitted with an absorbent cotton plug at the base and the neck contains a different sized needle. The length and the gauge of each needle are etched on the steel rack just below the appropriate groove. A needle range from ½ to 5½ inches and 26 to 15 gauge is provided and includes skin wheal, continuous spinal and splanchnic needles.

To perform a nerve block, the appropriate needles are used in conjunction with a packaged spinal anesthesia tray to pro-


Fig. 1.
vide syringes, towels, sponges, clips, etc. On completion of a block, the anesthesiologist inspects the needle for fitness for further use. It is then cleaned with water, alcohol and ether, pushed through a small square of white tissue paper, and resterilized in the test tube under high pressure steam. Since the tissue paper turns brown with heat, it provides visual evidence of sterility. The paper is discarded each time. In addition, the entire rack and its needles is re-autoclaved as a unit once each month to ensure the sterility of those needles used infrequently.

This needle rack, in use, has provided real convenience and aid in performing nerve blocks. It is felt that the useful life of the needles also is prolonged.

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SUCCINYLCHOLINE IN THE TREATMENT OF TETANUS

The following case report tells of our experience in treating a 52 year old male with severe clinical tetanus by the use of antitoxin, early elective tracheostomy, continuous intravenous infusion of Anectine® - (succinylcholine) for six days, and the Drinker-Collins respirator. The patient died of acute coronary occlusion on the thirteenth day of his disease (the sixth day of treatment).

Cholinesterase determinations were done serially and were normal. The total amount of succinylcholine was 28.35 Gm. in a period of six days.

Progress in the treatment of tetanus has had a long and interesting evolution, but treatment has yet to be perfected. The role of prophylaxis, surgical treatment, antibiotics, and antitoxin will not be discussed. Each sedative drug has had a useful era but has increased the hazards of respiratory complications and cellular anoxia in the large dosage needed to reduce the muscle spasms (7). The muscle relaxants have claimed an increasing therapeutic role since the early use of crude curare (reported by Sayres in 1859, by Wells and Villa in 1859, and by Busch in 1867). d-Tubocurarine, curare, curare in oil and wax, mephenesin and Flaxedil® have all been used to reduce convulsive seizures. Goldman and Adriani (1) have reviewed their experience with the various muscle relaxants.

Succinylcholine, an ultra-short-acting muscle relaxant, has established it usefulness in clinical anesthesia for the production of muscle relaxation during endotracheal intubation and prolonged surgical operations. Its use in clinical tetanus has been presented by Woolmer and Cates (6), and by Hamilton, Tovell, and Barbour (8).

In the treatment of tetanus, the use of an elective tracheostomy often is necessary to prevent asphyxia and respiratory complications (2, 3).

Artificial pulmonary ventilation has been recommended either for emergency periods or during periods of induced muscle facies (2, 4, 7).

Case report. This 52 year old white male gardener was admitted to the University of Oregon Medical School Hospitals and Clinics on April 30, 1954, with the complaint of inability to open his jaws for three days. This illness started on April 27 with a drawing sensation of the mandibles associated with excessive sweating and a productive cough. He had small wood splinters under his fingernails but no evidence of tenderness or abscess formation. He was employed as a gardener and had pulled weeds with his fingers.

Past medical history revealed that he had had moderate substernal pain while working for several years. There was no history of immunization, injury, or surgical operation.

Upon admission, physical examination revealed a well nourished, robust white male. He was mentally alert, cooperative, and diaphoretic. His oral temperature was 100.4° F., the pulse rate was 100 and of normal quality, the blood pressure was 150/108 mm. Hg. His skin was clear, cool, moist, and of a normal color. There was moderate spasm