ABSTRACTS

Editorial Comment: A fixed style of presentation for this department of Anesthesiology has purposely not been defined. It is the wish of the Editorial Board to provide our readers with the type of abstract they desire. Correspondence is invited offering suggestions in regard to the length of abstracts, character of them, and source of them. The Board will appreciate the cooperation of the membership of the Society in submitting abstracts of outstanding articles to be considered for publication.


"Our objective has been to utilize this principle of 'differential subarachnoid block' to develop a safe method which would (a) afford early pain relief without interfering materially with the progress of labor; (b) allow the patient to assume any comfortable position; and (c) obviate the necessity of continuous observation of the level of anesthesia by the anesthetist. The recent development of a vinylite catheter that can be autoclaved repeatedly and can be introduced into the subarachnoid space through a special thin-walled 18-gauge spinal needle simplified this problem. . . . The observations here presented were made on 52 parturients. . . . Continuous-drop spinal anesthesia was started when labor had definitely begun. . . . The skin and underlying structures at the level of the third lumbar interspace were infiltrated with 1 ml. of Novocain-ephrine solution. A spinal tap was then made with the special 18-gauge needle and the vinylite catheter introduced 1 inch into the subarachnoid space. . . . Immediately following a uterine contraction, with the patient in the sitting position, 2 ml. of 2.5 per cent procaine solution were introduced slowly from a Luer-Lok syringe. Forty-five to 60 seconds after this injection, the patient was asked to lie flat on her back. She was kept in this position until the level of hypalgesia to pin prick extended to the tenth thoracic dermatome. The patient was then elevated to a semi-recumbent position by raising the back rest to an angle of 45 degrees. . . . "A continuous-drop subarachnoidal infusion of 0.5 per cent procaine hydrochloride was begun at the rate of 3 to 4 drops per minute. With the tunnel clamp adjusted to deliver 4 drops per minute from the reservoir flask, 20 drops measured 1 ml. if the fluid level in the flask was 40 inches above the level of the patient's back. . . . Because the method allows a great latitude in the level of analgesia, the continuous presence of the anesthesiologist is not necessary. The technique is safe. Maternal and fetal complications attributable to the method were negligible."


"Palsy of the sixth cranial nerve following spinal analgesia has been reported regularly since soon after the introduction of this method of pain
relief, and it is perhaps a reflection on anaesthetists that most of the communications on this subject come from ophthalmologists. The incidence of the complication is difficult to determine. Mild degrees of abducens paralysis probably pass unnoticed or unheeded; and although the highest figure given, 1% of all spinal analgesics, by Terrien (1923) is considerable, it is possible that the figure should be considerably greater. . . . The sequence of events is remarkably constant. The paralysis is not noticed until 3 to 21 days after the spinal analgesia, but it is preceded by a period during which the patient complains of severe headache and perhaps dizziness, nausea, stiff neck, photophobia, and diplopia. The delay in onset of the palsy has given rise to many theories about its causation, none of which is subject to proof. . . . Two cases have occurred recently in our hospital—one following simple lumbar puncture, the other after a spinal analgesia. . . . These two cases have two points in common. A large-bore needle was used, causing a rapid loss of a comparatively large volume of cerebrospinal fluid, and external rectus paralysis developed in the eye opposite to the side on which she was lying. The brain, deprived of its water cushion through the sudden loss of cerebrospinal fluid, sags and a strain may be thrown on the sixth nerve, which is uppermost. The nerve is stretched, but the lesion is due primarily to reduced and not to raised intracranial pressure, as suggested by Fairelough."

A. A.


"On a busy industrial surgery service which handles casualties sustained on two major railroads and a number of industries there are frequently severe injuries including fracture of major bones, burns and extensive soft tissue trauma. The care of these requires a means of relieving the initial pain and suffering, and the provision of an efficient, safe and convenient anesthesia during the procedure of definitive care of fresh wounds, the manipulation of fractures, the application of casts and special appliances, and the cleansing and debridement of burns. In cases where the use of narcotics is not contra-indicated . . . morphine and scopolamine given by hypodermic injection in divided doses have provided us with such a method. These patients may be placed deeply under morphine and scopolamine anesthesia, and the work easily and leisurely done without supplemental anesthesia. . . . Our own experience with the use of morphine and scopolamine dates back to 1918. . . . Since the inception of its use at the Washington Boulevard Hospital in 1918 it has been given routinely in approximately 20,000 cases. Morphine-scopolamine has been given to all patients 15 years of age and over where an anesthetic was required. . . ."

"It is essential in transferring the patient from the bed to a cart, transporting him to the operating room, placing him on the operating table and in the administration of further anesthesia, that the patient be disturbed as little as possible, and quiet maintained. . . . Because our experience in the emergency department and in the operating room has shown us that morphine-scopolamine alone or with supplemental anesthesia and curare provides a very satisfactory anesthetic presenting (1) safety; (2) ease of administration and control; (3) absence of respiratory complications; (4) diminution of frequency of postoperative nausea and vomiting; and (5) warm acceptance by the patient, we enthusiastically present and