ties when discharged eight weeks after operation. He died one month after discharge but unfortunately permission for autopsy could not be obtained.

This report illustrates an unusual neurologic complication following exploratory thoracotomy under ether anesthesia. At no time was there any period of mental derangement, cyanosis or other evidence which might lead one to suspect the possibility of damaging hypoxia during the surgical procedure or during emergence from anesthesia. Embolus (question of air entering the circulation by way of the pulmonary vein) or thrombosis of the anterior spinal artery appeared to be the most likely diagnosis. Goodwin and Harmel (1) have described a similar paraplegia in a dog after intra-arterial injection of oxygen into the lower abdominal aorta. They believed that gas embolus had caused necrosis of the spinal cord. In our case we are certain that if such an accident had followed spinal anesthesia, the symptoms would have been falsely ascribed to the local toxic effects of the anesthetic agent. Perhaps some complications which have been attributed to spinal anesthesia may be caused primarily by the operation or may be merely coincidental.

REFERENCE

PHILIP THOMAS, M.D., and CLEMENT S. DWYER, M.D., Department of Anesthesiology, Eastern Maine General Hospital, Bangor, Maine

ALUMINUM CHART BOARD PROTECTOR FOR INTRAVENOUS INFUSIONS

Frequently it is advantageous for the anesthesiologist to introduce intravenous solutions into a vein of the upper extremity. To prevent displacement of intravenous needles by the surgeon or his assistants, a Wells arm protector (Forger Co., New York, Catalogue No. 9, 1949, No. 165, Page 79) has been used with the upper extremity placed at the side of the patient. If the needle should become plugged it would be difficult to perform any manipulations to correct this condition, especially when the patient has been draped. The outstretched arm is the preferable position for access to veins. A modification of the Wells arm protector has been made of an almost similar type arm protector which is smaller in size. This is made from an aluminum chart board (fig. 1). This chart board is flexible.

![Fig. 1. Aluminum chart board protector for intravenous infusions.](image-url)
and can be easily molded into any shape to fit the curve of the elbow or wrist. The attached chart clamp on the chart board is removed. The upper extremity is outstretched upon an arm board and the convex portion of the chart board faces the surgical team who frequently lean against an outstretched extremity. In this manner the resistance of the metal chart board allows pressure against the elbow or wrist without displacing the intravenous tubing or needle. The horizontal portion of the chart board is placed between the arm board and the upper extremity. An arm board 6 inches wide and 36 inches long is used. The horizontal portion of the chart board extends beyond the arm board. This extended portion can be used for holding syringes, needles and sponges that are to be used. To prevent these items from falling the end of the horizontal portion is curved upward.

An arm board with the chart board protector should be perfected so that the arm board is not attached to the operating table but can be adjusted to any height or moved in a 180 degree arc, either in a horizontal or vertical direction. This would be especially valuable in obese patients and patients with deformed upper extremities.

Zigmure Harris, M.D.
Director,
Department of Anesthesia,
American Hospital,
Chicago, Illinois

CORRESPONDENCE

To the Editor:

In an editorial in the September 1949 issue of Anesthesiology is mentioned the fact that the problem of gaining national professional status by anesthesiologists is in no wise made easy by their name, which is long, cumbersome, tongue-twisting, and very similar to “anesthetist” which in the mind of the general public often means a technician.

I would like to submit to you, and to the members of the American Society of Anesthesiologists in general, a new name which is fairly appropriate, is built from an entirely different root, is shorter, and is much more easily pronounced. My idea is to take “narcosis” as the base word, call the specialty “Narcoology,” and ourselves “Narcoologists.”

Goodman and Gilman’s “Pharmacologic Basis of Therapeutics” defines narcosis as “a condition of analgesia accompanied by a deep sleep or stupor.” That describes general anesthesia pretty well, doesn’t it? I grant you that it is not too descriptive of spinal or regional anesthesia, unless one can consider that in this case a part of the body is put to sleep. However it is much more nearly applicable to regional anesthesia than “Orthopedics” which means “straightening children” applies to the treatment of bone and joint pathology in all ages.

“Narcoologist” is certainly as far removed from “Anesthetist” as “Obstetrician” is from “Midwife,” or “Psychiatrist” is from “Faith Healer;” so it should escape the connotation of “technician.”

I realize that it would be a difficult task to change the name of our specialty, but if it could be accomplished, the benefits would be many.

It would be nice to have a title that patients could pronounce.

Carl H. Guild, Jr., M.D.,
2100 W. 39th,
Kansas City, Kansas