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.


A 56 year old woman suffering from hypertension underwent an operation for the relief of partial intestinal obstruction due to adhesions. The induction and maintenance of anesthesia were with cyclopropane using the endotracheal absorption technique. A moderate amount of ether was administered for 5 minutes following induction. After the operation commenced curare 3 cc. (intocostrin) was administered. Within a three minute period the respirations ceased and artificial respiration was started. The operation consisted of lysis of intestinal adhesions and was finished in 1 1/2 hours. The patient at this time had a good color, the pulse was strong with a rate of 84 and the blood pressure was 160/90. Artificial ventilation was carried out with oxygen for 8 hours. It was necessary to maintain vigorous artificial respiration with pure oxygen to prevent arterial anoxemia.

Some resistance to inflation of the lungs was experienced throughout the entire period of artificial ventilation but at one time it became extremely difficult to inflate the lungs. Bronchial rales were heard on auscultation but no mucus could be aspirated from the trachea. Accordingly 1 cc. of adrenalin was given intravenously. Immediately it became easier to inflate the lungs and the bronchial rales disappeared. But this effect was only transitory and soon again lung inflation required as much force as before the adrenalin.

At autopsy the patient had bilateral pulmonary collapse with no evidence of tracheobronchial obstruction. The history and physical findings did not offer any evidence of myasthenia gravis. No completely satisfactory explanation for the prolonged curarization and the massive pulmonary collapse could be made but it was considered that in some manner they are most likely related to the administration of curare.

R. F.


"Anesthesiology—the study and practice of the art and science of anesthesia in all its forms and all that pertains thereto, began in 1846 as the clinical administration of one agent, by one method for one purpose, the relief of pain. . . . Anesthesia was accepted promptly by physicians the world over, but, in the United States, recognition as a specialty came only after ninety years. . . . During the 1931 Congress of Anesthetists, held in New York, a committee was established to seek a proper means to designate a specialist in anesthesia. After two years of failure of twelve well qualified anesthetists
to arrive at a solution, the New York Society of Anesthetists established in 1933 a Committee on Fellowship to attempt certification of anesthetists truly qualified as specialists. . . . This work led to the formation on June 2, 1937, of the Section on Anesthesia of the American Board of Surgery. In 1941, it was recognized as a separate major specialty board. . . . The basic requirements of all specialty boards are similar or identical. Briefly they are: (1) graduation from a grade A medical school in the United States or Canada, (2) minimum of one year of internship in an approved hospital of the United States or Canada, (3) special training in the specialty, (4) membership in the American Medical Association, (5) time (five years) in the specialty and (6) examination in various forms. The anesthesia board had no founders' group, all candidates having to meet identical standards. . . .

"No specialty board is a union, and it does not issue degrees or licenses for any special practice. It merely sets standards for those who voluntarily seek its designation as 'specialist.' The boards do not approve or withdraw approval of residencies. . . . It does confer with the specific board concerning specialty items. . . . The American Board of Anesthesiology has never required that heads of approved residencies must be specialists certified by the board. Some certified specialists have no special ability or desire to teach. This board knows that there are hundreds of physicians who are factually qualified to practice anesthesiology who would not or could not seek certification by this board. . . . Examinations are abominations to all concerned. They have been used in some form in all known human endeavor to ascertain true fitness for special designations indicating proved qualities, and this board has found no substitute. It has, therefore, set up a system of three types of examination—written, oral and practical. One application covers all, and advancement is automatic on successful completion of a preceding part. . . .

"The written examinations were of the essay type until 1948, when a change was made to the multiple choice, International Business Machines type of examination. . . . Practical examinations are given in all instances when no member of the board has observed the candidate work or the board does not know the local situation in relation to the problems of the anesthetist. . . . Variations in the material covered and in the accepted answers caused an appeal for a fixed curriculum. Local working conditions do not permit a formal rigid pattern to be established in all centers. There is available through the American Society of Anesthesiologists and the American College of Anesthesiology a booklet, 'Anesthesiology,' giving in concise form the major requirements and reference texts. It will be sent on request to members of those groups or for a small charge (twenty-five cents) to nonmembers. The outlines or patterns for three types of approved residencies are included in the booklet. They are adapted for a large hospital, a small hospital and a medical school-hospital combination department."

J. C. M. C.


The authors' report on the pharmacology and early clinical tests of tri-(diethylaminoethoxy)-benzene triethyl iodide, also known as R.P. 3697 and now called "Flaxedil."

The action of Flaxedil is like that of curare, inhibiting the transmission of nervous impulses by acetylcholine and blocking transmission across the myo-