CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a section in ANESTHESIOLOGY in which will appear invited and unsolicited professional and scientific correspondence, abbreviated reports of interesting cases, material of interest to anesthesiologists reprinted from varied sources, brief descriptions of apparatus and appliances, technical suggestions, and short citations of experiences with drugs and methods in anesthesiology. Contributions are urgently solicited. Editorial discretion is reserved in selecting and preparing those published. The author’s name or initials will appear with all items included.

BREAKAGE OF MAGILL FORCEPS
(A Case Report)

The literature does not contain many reports of technical complications during intubation. I have been unable to find any reference to the breakage of endotracheal equipment as encountered in the following case.

A 75-year-old French-Canadian was admitted to the hospital on June 3, 1948, for treatment of a carcinoma of the tongue. Physical examination was otherwise negative, except for the presence of generalized arteriosclerosis and moderate hypertension. He was classified as anesthetic risk 3.

On June 6 radon seeds were implanted into the lesion of the tongue. Pantopon, 1/6 grain, and scopolamine, 1/200 grain, were given subcutaneously ninety minutes before operation and produced adequate sedation.

Anesthesia was induced with sodium pentothal (2 per cent) and d-tubocurarine. A total of 15 cc. of the mixture with 300 mg. of pentothal and 12 mg. of curare was given over a period of about five minutes and produced sleep and good relaxation. Blind intubation with a number 8 Magill portex tube failed. After repeated autoclaving the tube had become too soft, despite refrigeration for about one hour. The larynx was then exposed without any difficulty, but intubation under direct vision failed again. Because the tube was soft we were unable to direct it either by rotating it or moving the patient’s head. Magill forceps was then used to direct the tube into the larynx and intubation was easily completed in five minutes without trauma or any other unusual occurrence. Anesthesia was maintained with cyclopropane (closed carbon dioxide absorption).

When the surgeon (Dr. B. Lambert) exposed the lesion, a foreign body was seen at the base of the tongue and retrieved. It was a fragment of the Magill forceps, about 5 mm. long and 2 to 3 mm. wide, semi-circular in shape.

Operation and convalescence were otherwise uneventful, and patient was discharged on June 16.

Unable to determine why the forceps broke, we asked the manufacturer about it. The forceps had been in use for about two years and had been used about fifteen times. The manufacturer wrote us as follows:

“In reply to your letter of the 26th regarding the broken Magill Forceps, we cannot find any evidence of a defect in these forceps and since such a thing has never happened before, we do not know what to say about it.

“The instrument maker’s opinion is that the forceps in question have apparently been dropped at some time or other, probably during the process of cleaning or sterilization. Since this is necessarily a small and delicate instrument, it is not able to withstand hard usage and dropping the instrument on the point would cause a crack and eventually breakage. Since there is apparently no inherent defect in the instrument we do not know what else to suggest as the cause of this happening.”

We were extremely fortunate in retrieving the fragment before it was aspirated. Two conclusions seem obvious:

(1) Extreme care in the handling of all endotracheal equipment during cleansing and sterilization is particularly important.
A CASE OF SEVERE DERMATITIS VENENATA DUE TO METYCAINE

So far as we have been able to determine, there have been no reports of local allergy to metycaine. Since a patient suffered a severe dermatitis on the University of California Service, San Francisco City and County Hospital from this agent, the following case report may be of value to those who use metycaine.

On March 7, 1948, a 34-year-old pregnant, white, married housewife, gravida V, para IV, whose expected date of confinement was April 1, 1948, entered the San Francisco City and County Hospital, soon after an episode of profuse painless bleeding. After physical examination, a tentative diagnosis of placenta previa was made. Bleeding continued after entry. The patient was taken to the operating room, where a sterile vaginal examination revealed about 500 to 600 cc. of clotted blood in the vagina, and a firm cervix just admitting a fingertip. The internal os was not vigorously probed. A presumptive diagnosis of placenta previa or premature separation of a low-lying placenta was made. Administration of whole blood had been started shortly after admission, and the patient was in good condition at all times. A low cervical cesarean section with a vertical incision was performed under local anesthesia, using 1.5 per cent metycaine, obtained in a 200 cc. ampule.* A total of 35 cc. was infiltrated into the skin, and an additional 55 cc. was injected beneath the anterior rectus sheath. The procedure was carried out without difficulty and a viable female infant was delivered. The placenta was noted to cover the internal os partially.

The patient’s immediate postpartum course was essentially uneventful. The maximum rise in temperature during the first week of puerperium was 100°, on the second postpartum day. On the seventh postoperative day, the dressing was taken off to remove the skin sutures. At that time, an area neighboring the incision for 7 to 8 cm. in all directions was covered

* Number 400, Eli Lilly Company.

with a weeping vesicular (often bullous) dermatitis. The incision itself showed only very minor superficial separation. The patient was treated with benadryl, 50 mg. four times daily, and phenobarbital to allay the intense itching which developed at this point. A dermatologist called in consultation described the condition as "erythema, edema and vesicular formation over the abdomen with superficial separation of the midline incision," and his impression was that the patient suffered from a dermatitis venenata due to metycaine. In addition to antihistaminic drugs, compresses of cool Burow’s solution were prescribed. A patch test was applied using 1.5 per cent metycaine from a 200 cc. ampule. In twenty-four hours, the response was unmistakable. There was a red, raised, bullous lesion which itching considerably. This reaction resembled the dermatitis which had developed at the site of incision. A patch test with merthiolate, which was also used in surgery, was negative. Before this operation, the patient had had no previous local anesthetic agent so far as she knew. She was most uncomfortable until about the fifteenth postoperative day. By the eighteenth day, the skin of the abdomen had dried and crusted completely, the pruritus had decreased considerably, and it was thought that she might be discharged.

Six week follow-up examination showed that the area had cleared completely and the patient was well.

This case of allergy to metycaine is reported because of its general interest and apparent rarity. It may be of value to those who use this anesthetic agent in the spinal or caudal canals, or in the skin, to rule out sensitivity by skin tests before injection of considerable doses.

J. A. KERNER, M.D.,
AND M. L. KAMM, M.D.,
Dept. of Obstetrics and Gynecology,
University of California,
San Francisco, Calif.