CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a new department in ANESTHESIOLOGY. In it will appear invited 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.

ELECTIVE EARLY INTUBATION

For years I have been practicing the technic of blind intranasal intratracheal intubation which has been an astonishingly simple procedure, and of great practical value. I do not make claims to originality, but as far as I can ascertain, the description of this technic has not been too well described in the literature.

I refer to the technic of intubation while the patient is still awake and fully able to cooperate with the anesthesiologist. No attempt is made at general anesthesia until the intratracheal tube is definitely and properly placed. This method is especially well adapted to use in cases of trismus, retropharyngeal abscess, tumor of the floor of the mouth and of the tongue, tonsillectomy, and plastic operations about the face and neck, as well as in those cases in which a combination of anatomical factors related to the opening of the jaw and prosthetic dental work makes it advisable to perform nasal intubation rather than oral intubation for the operation indicated.

My technic has been to prepare the patient with the usual premedication for the general anesthetic that is planned to follow the intubation. I carefully explain to the patient what the intubation procedure will be and have in every case obtained complete cooperation. In each case the nose is well sprayed with 20 per cent cocaine solution, while the patient is taking deep breaths through the nose. The cocaine solution is preferred to other anesthetic solutions because it shrinks the mucosa of the nose, allowing for easier passage of the nasal tube. The taking of deep breaths through the nose allows the spray to anesthetize the pharynx, vocal cords, and the trachea. Usually the average adult, after cocaineization, will have enough space in the nasal passages to accommodate a number 6 Magill type nasal intratracheal tube of from 22 to 26 cm. length, as described by Lundy. Naturally, this is subject to individual variation. The tube is lubricated well with 2 per cent In- tracaine ointment, or with any bland, anti- septic, or anesthetic lubricating medium that may be preferred by the individual anesthesiologist. It is of great importance to have the intranasal intratracheal tube well lubricated.

The tube is inserted into the nostril, the patient's head is flexed to what may best be described as the "sniffing" position, and the tube is gently passed to a point just below the base of the tongue. This position may be checked by direct vision, but is easily arrived at through experience. At this time the patient is told to take a few deep breaths, for the psychologic effect as well as to enable the anesthetist to listen with an ear to the end of the intratracheal tube, to check on the position of the tube. Then, as the patient is inhaling deeply, the tube is gently advanced, synchronously with an inspiration, and almost invariably it enters the trachea on the first attempt. The intubation is aided by the presence of the tone in the muscles of the pharynx which, upon inspiration, form a trough along which the tube is guided into the space below the epiglottis and between the vocal cords. The procedure is done slowly, calmly, and confidently for the psychologic effect upon the conscious patient.

Once the intubation has been completed,
the patient is unable to talk, and therefore constant reassurance by the anesthesiologist that the procedure has been successfully done and that the patient is cooperating well, will be appreciated by the patient. From this point on, with a guaranteed airway, complications are negligible. I prefer then, in each case, to induce general anesthesia with intravenous sodium pentothal, after the manner of Lundy, using a 2.5 per cent solution. I can see no additional advantage to changing over to any other anesthetic at this point, unless relaxation is important for the surgical procedure to be performed. It is perfectly feasible to induce general anesthesia with sodium pentothal, and then to maintain anesthesia with any of the inhalation anesthetic agents. I believe that it is advisable when using sodium pentothal to administer 100 per cent oxygen or 50-50 per cent oxygen and nitrous oxide through the intratracheal tube after the patient has become unconscious. Postoperatively, I leave the intratracheal tube in place until the patient has definitely recovered from the general anesthetic agent.

Most anesthesiologists have seen the following circumstances develop when a patient has been brought to surgery for anesthesia. General anesthesia has been started, the patient has developed a laryngeal spasm, has had difficulty with the tongue falling back into the pharynx, has had complications as a result of muscle relaxation allowing eystis to shift and to cause respiratory obstruction, has been in too light a plane of anesthesia for oral intubation and, at the time of an attempt at nasal intubation after induction, may be found to have abnormalities of the nasal passages or of the pharyngeal structures that make either oral or nasal intubation difficult. The method I describe obviates all of these complications, increases the peace of mind of both the surgeon and the anesthesiologist, and contributes to the safety of the patient.

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CURARE IN ADULT TONSILLEKTOMY

The reports in the literature have absorbed themselves primarily with the use of curare in abdominal surgery. It occurred to us that it might be advantageously employed in adults undergoing tonsillectomies under general anesthesia. We appreciate the fact that local infiltration has been the method of choice in adult tonsillectomy and will probably continue as such. But occasionally, for some reason or other, an adult insists on "going to sleep." It is this particular case that has always proved to be the dread of our anesthetic staff because of the extreme depth of ether anesthesia required to relax the jaw and permit adequate exposure for surgical procedure.

Our series consisted of 12 cases varying in age from 16 to 40 years and in weight from 105 to 200 pounds. In determining the dosage of curare, we took into consideration several previously established facts. In the first place, it has been shown that the head muscles are among the first to respond to the action of curare. Furthermore, ether, which was the basic anesthetic employed, has in itself a curariform action thereby permitting a reduction in dosage of curare used. Owing to the paucity of cases we were permitted no experimental latitude but arrived at an arbitrary technic that was used throughout the series.

TECHNIC

Morphine gr. 1/4 and scopolamine gr. 1/100 was given one hour preoperatively in all cases. Nitrous oxide-oxygen in a semi-closed system was used for induction and ether gradually added until the first plane of anesthesia was reached. At this point the jaw was rigid. Thirty mg. (1½ cc.) of curare (Intoecorin, Squibb) was given intravenously. Within one minute, the mandible was sufficiently relaxed so as to permit the use of a mouth gag and the surgery started. Maintenance was by oral insufflation of ether as usually employed. No additional curare was necessary for the initial or for maintained relaxation.