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.

CORRESPONDENCE

To the Editor of Anesthesiology:

The excellent contribution of Seymour Schottz on "Pulmonary Atelectasis" (Anesthesiology 4: 293, No. 3, May, 1943) appears to me to cover the subject from the anesthetist's point of view in a highly satisfactory manner. However, I believe that the case reported as one of "aute massive collapse" permits of another interpretation.

It has been suggested, it is true, that active contraction of the pulmonary tissues may result in atelectasis. Nevertheless after death the neurologic stimulus to contraction must cease. Vigorous artificial respiration ought then to reinflate the lungs. It seems to me difficult to believe that "each lung" could remain "shrunk to about one-third its normal size" at postmortem examination if a half hour of vigorous artificial respiration had been applied. Is it not conceivable either (a) that through over-vigorous inflation of the lungs certain alveoli were ruptured into the pleural cavities, or (b) that attempts to place a needle in the heart might have opened the pleura? As a result of prolonged vigorous artificial respiration by direct inflation "large circumscribed hemorrhagic patches over the surface of the lung" have been found, as have "a combination of atelectasis, edema and hemorrhages into the alveoli."

May I suggest that Dr. Schottz might have been justified in interpreting the postmortem findings in the chest of his patient as those resulting from the accidental production of bilateral pneumothorax during efforts at resuscitation, either pre- or post-mortem.

RALPH M. WATERS, M.D.,
Department of Anesthesia,
State of Wisconsin General Hospital,
Madison, Wis.

A RUNNING COMMENTARY BY PERIPATETIC CORRESPONDENTS *

My dear Nephew,—I am glad to hear that the offending appendix has been removed, and that you are well on the way to recovery. I note that you now want to be an anesthetist when you are older, and would like to know something about the art of anesthesis.

* Editor's Note. The above was received by the Editor from Ralph M. Tovell, Lt. Col., Medical Corps, Senior Consultant in Anesthesiology, Office of the Chief Surgeon, European Theater of Operations, as a copy of an interesting letter in the issue of The Lancet dated May 3, 1943, which Lieutenant Colonel Tovell thought to be suitable material for reprinting in Anesthesiology. Therefore, in his capacity as Associate Editor, he wrote to the Editor of The Lancet requesting permission to reprint this letter in full in Anesthesiology if the Editor so desired. Its publication here is reprinted through the courtesy of The Lancet as the result of the interested solicitation of Lieutenant Colonel Tovell.
You must get out of your head all the classical jokes. “Dr. Jones, surely if the patient can keep awake, you can too?” or “Dr. Smith, my end seems to be awake, how’s yours?” may have been applicable once upon a time (although I doubt it, since anaesthetists, like Aberdonians, love to tell stories against themselves), but they are quite inadmissible now that the regiment has become mechanised. The “man half awake, bending over a patient half asleep” is by now a complete myth. When giving a volatile anaesthetic, the modern anaesthetist is like the stoker in an oil-fired liner—having set the taps, all he has to do is to give an occasional glance at the gauges to see that all is well. When he has given a spinal, he is like a country gentleman who, having done a good piece of rough shooting, spends the rest of the day before the library fire or pottering about in the greenhouse.

Anaesthetics can be exhibited by various routes—that is, they can be pushed in through most of the holes in the body. I cannot recall that they are given through the external auditory meatus, though you will remember that Hamlet’s father was taken for a ride by this route. The other day I witnessed a brain operation in which the patient was completely covered with cloths and a long tube from the anaesthetic trolley disappeared somewhere in the region of his abdomen. I tell you this to warn you against taking anything for granted in anaesthesia, for the anaesthetic was not being exhibited by the umbilical route. In the old days, when the patient stopped breathing, this was a matter of some importance. If it did not cause alarm and despondency, at least it called for prompt action. But your modern anaesthetist, who has cunningly slipped in an intratracheal tube, is not really happy until he has paralysed the respiratory centre. Only then is the patient bent completely to his will, only then does he rise to the top of his form as serenely, efficiently, contentedly he squeezes the life-giving bag. The number of drugs at the command of the anaesthetist is immense, and growing immenser. In addition, each drug is given several different names by several different firms, which adds to the apparent number.

I was once privileged to hear a medical man about to undergo an operation enumerate his wants to the anaesthetist, while Mrs. Beeton’s shade nodded smiling approbation. The Americans, who are invertebrate producers of new anaesthetics, have recently introduced one called “cypræth ether.” In this, however, they were forestalled by Shakespeare, who wrote:

“Fly away, fly away, breath,
And in sad cypræth let me be laid;
Come away, come away, death,
I am slain by a fair cruel maid.”

The last two lines have not been properly explained in the commentaries, since it is inconceivable that the poet could have had any doubt about the safety of this anaesthetic in the hands of a female anaesthetist.

If I were given to punning I would summarise thus: It all boils down to this, that despite a swift retreat, thereby averting disaster, the spirit of the old anaesthetists breathes on, and it will be realised in the future that the present generation has not worked entirely in vain. (Yes; you are right; five puns, all weak.)—Your affectionate Uncle George.

CASE REPORT—INFANT RESUSCITATION

The following cases are presented because they demonstrate a feasible method of resuscitation of the new born, and providing adequate oxygenation in the period immediately following resuscitation. All too often a baby is resuscitated but remains of poor color for a considerable period thereafter. The method described utilizes endotracheal insufflation as a means of resuscitation and provides a simple device for maintaining safely a continuous flow of oxygen into the trachea.

On January 7, 1943, a 25 year old multipara, in her sixth month of a twin pregnancy, was subjected to cesarean section for placenta praevia. Anesthesia consisted of upper second plane cyclopropane, ether, and oxygen. The first of the twins, A, from whose placenta the mother was bleeding, was born at 5:48 a.m. The baby was cyanotic, the heart rate slow and efforts at resuscitation with the Flagg apparatus, intermittent compression of the chest with oxygen by mask, and ephedrine were un-