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 anesthesiaology. 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.

INSERTION OF GASTRIC TUBES IN THE UNCONSCIOUS PATIENT

Frequently it becomes desirable to insert a Levine-type gastric tube during or immediately after a surgical operation. In the absence of the swallowing reflex this may be difficult, due to the tendency of the tube to coil in the pharynx, especially if the tube is comfortably soft. The following maneuvers have been used with success:

1. After suitable lubrication, the tube is started through one nostril, as far as the hypopharynx. A prop is placed between the teeth, and an index finger inserted into the patient's pharynx. The finger holds the tube firmly against the postero-lateral fold of the pharynx. This imparts enough rigidity to the tube that it may be pushed further into the nose, with assurance that its tip will enter the esophagus, and that it will not coil in the pharynx unknown to the anesthetist. In the writer's experience, this method has seldom failed.

2. If the patient's jaw is still well enough relaxed, the hypopharynx may be exposed with a laryngoscope, and with Magill forceps the tube can be pushed a little at a time into the esophagus.

3. In the absence of adequate jaw relaxation, but where the nasal passages are quite wide, a Magill tube with a flat curve may be first inserted blindly into the esophagus via the wider nostril. Coughing would indicate accidental tracheal intubation and a more flatly curved Magill tube tried, perhaps with more flexion of the neck. Once the large tube is in place, a well greased Levine tube will usually pass through it into the esophagus. (Occasionally the method will fail because the nasal passage compresses the outside tube so much that the less compressible gastric tube will not pass.) The Magill tube is then carefully withdrawn, leaving the Levine tube in place.

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PREANESTHETIC BREAKFAST

It is usual for patients scheduled for operation in the afternoon to have nothing to eat for some eighteen hours before operation. This period of starvation probably produces undesirable lowering of blood sugar and of glycogen reserve. To prevent this condition, the following high-carbohydrate, low-residue breakfast has been given to many patients, without ensuing trouble, four or more hours before operation:

Grape juice Cream of wheat Boiled milk Sugar Zwieback or Melba toast

It is probable that any of the following foods could also be used:

Prune juice Malted milk Broth with rice or noodles Gelatin Jelly Farina Cold cereals without bran Crackers Rusk Macroni Spaghetti Hard candy

Orange juice should not be used, for it may be vomited several hours after ingested. Coffee and tea may be objectionable on account of their stimulating effect.

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