PROTECTIVE SHIELD FOR CONTINUOUS SPINAL NEEDLE

In operations of long duration under continuous spinal anesthesia by the needle technique, when the patient is to be operated upon in any position other than the supine, a frequent complication is that the needle may move out of place. This is even more

![Image of protective shield](image1)

**Fig. 1.** Protective shield.

![Image of protective shield in position](image2)

**Fig. 2.** Protective shield in position over lumbar vertebrae.

*Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.*
likely to occur in spine fusions, nailings of 
the hip and similar procedures when sur-
gical procedures are done in close prox-
imity to the spinal needle.

This disadvantage could be eliminated by 
administration of a long lasting “single 
dose” spinal anesthetic agent, or by the 
continuous catheter technic, but these pro-
cedures either may not be indicated or the 
equipment may not be available. A simple 
device effectively prevents dislodging the 
spinal needle if needle technic is chosen:

The malleable needle is inserted as usual. 
The needle is bent sharply at the skin edge. 
It is secured by holding it with forceps 
close to the skin. The needle is held in its 
position by padding it with gauze and then 
covering it with a protective shield taped 
to the patient's back. This shield is made 
of plexiglass, 7 by 14 cm. in size, and 0.5 
cm. thick. It is bent so that a channel is 
formed deep enough to provide adequate 
space for the needle.

Self-retaining retractors may be placed 
above this shield so that traumatic manip-
ulations can be performed without disturb-
ance of the continuous spinal apparatus 
with this technic. We have employed the 
method successfully in 27 consecutive cases.

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To the Editor:

Dramamine is being used empirically in 
a variety of conditions which are accom-
panied by nausea. Since there is a pos-
sibility that it may have a direct effect on 
the vomiting center, we have tried the drug 
as a preoperative medicant in order to 
study its influence on the occurrence of 
nausea and vomiting following operation. 
So far it has been employed in 100 con-
secutive cases in which major surgical pro-
cedures were performed under cyclopro-
pane anesthesia, in most instances with 
sodium pentothal induction, a few with 
the addition of ether. Cases in which other 
types of anesthesia were used were omitted 
from the series. One hundred comparable 
cases were observed as controls.

An exact evaluation of the results is 
extremely difficult and a much larger num-er of patients must be treated to prove 
whether or not the impressions gained so 
far are consistent. Only an extended pe-
riod of observation would justify disre-
garding the large number of variables, 
such as age and sex of the patient, indi-
vidual disposition, the particular illness, 
type and duration of the operation, the 
influence of other drugs and so forth.

Doses of dramamine given were 100 to 
200 mg. one to two hours before opera-
tion. Results seemed to improve with the 
larger amount which, in addition, produces 
marked sedation without undue depression. 
Possibly even larger doses should be used. 
It appears, however, that postoperative 
rectal medication with 200 mg., as sug-
gested by Dr. Peterson in the November 
1949 issue of Anesthesiology, is more 
effective.

The incidence of postoperative nausea 
and vomiting is definitely decreased after 
administration of dramamine, although not 
dramatically so. In our series, 48 per cent 
of the premedicated patients were en-
tirely free of nausea and vomiting as com-
pared with 42 per cent of the control 
series. Nausea and vomiting occurred in 
17 per cent of the premedicated cases and 
in 29 per cent of the controls. The re-
mainder of the patients were classified 
somewhere in between when they exhibited 
only slight or transient nausea. Quite a 
few patients denied having any nausea al-
though they had to regurgitate fluids or 
food which they took within about eight 
hours after operation. They were com-
fortable after emptying the ingested ma-