mucus tinged with blood, and the spray of cocaine was repeated twice through the tube to minimize this. The endotracheal tube was probably partially obstructed by a kink in its course through the nose, for it proved impossible to pass a catheter for the aspiration of secretions more than 4 inches into it. The patient could, however, blow his secretions to this point in the tube, and from there they were removed by aspiration every time he coughed. Neither retching nor vomiting occurred at any time after operation.

During the night after operation the patient became restless. His temperature rose to 104 F. and his pulse rate to 140. Sedation was partially achieved by the administration of 2 drachms of paraldehyde, diluted with warm water, through the gastric tube. The next morning he was still restless, and his general condition and flushed appearance suggested the presence of infection. The swelling of the neck had decreased. In the afternoon it was found that when the gastric tube was removed the patient could breathe through that nostril around the endotracheal tube when the orifice of the latter was occluded. A few moist adventitious sounds could be detected at the left base, but the breath-sounds remained vesicular. That evening he appeared to have difficulty in breathing and oxygen was administered through the endotracheal tube.

On the morning of the second day, the swelling of the neck having decreased still further, the tube was removed exactly fifty-one hours after its insertion. The patient was able to phonate normally at once although the condition of his mouth rendered normal speech impossible, and stated that he felt greatly relieved by the removal of the tube. He denied any discomfort in the region of the glottis, and said that the slight pain which he had previously experienced in the right side of his chest had disappeared. He seemed able to breathe through his mouth and nose without difficulty. Three weeks after the operation, having recovered, he was sent home. When last seen, over two months after the operation, there had been no complications.

COMMENT

Tubes allowed to remain in the trachea for long periods of time should probably be removed periodically to be cleaned. When this tube was examined, at extubation, its lumen, though still patent, was found to be narrowed by debris and mucus adhering to its inner wall. It might have been removed twenty hours earlier than it was. After thirty hours it had become partially obstructed by clotted mucus and gave rise, from then on, to some obstruction to respiration. Those in charge of the case were naturally reluctant to remove it until all danger of obstruction of the air passages was past. Nevertheless the fact that it was left in situ after operation probably spared the patient a tracheotomy.

Although cases in which the prolonged use of a laryngeal airway is of value are rare, I believe an anesthetist will sooner or later encounter such a one. I am aware of several similar cases in the experience of other workers, and claim no originality in the matter. The purpose of this report is rather to draw attention to this therapeutic use of intubation, and to solicit the publication of further evidence on the subject by others.

REFERENCE

1. MacEwen, W.: Clinical Observations on the Introduction of Tracheal Tubes by the Mouth Instead of Performing Tracheotomy or Laryngotomy. Brit. M. J. 2: 122–124 and 163–165 (July) 1880.

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TECHNICAL SUGGESTION

The routine abduction of one of the patient's arms on a narrow well-padded board during the operation rarely inconveniences the surgeon or his assistants during operations below the diaphragm. The accessibility of the arm makes for less confusion when intravenous therapy or anesthesia is required or when adjustments of the blood pressure apparatus are necessary during the operation. J. K. P.