on expiration. Cyanide acts similarly, except that in cases where the hyperpnea is extreme there may be a second phase of expiratory augmentation, due probably to inspiratory fatigue. Hemorrhage results in an increased expiratory lung volume possibly due simply to the decrease in volume of thoracic and abdominal contents.” 6 references.

J. C. M. C.


The author cites several cases taken from his own experience and from the literature of severe respiratory obstruction caused by an impaction of the epiglottis in the larynx. The condition is thought to be due to a combination of the factors of muscular relaxation of the tongue and posterior inclination of the epiglottis. The relaxation of muscles allows this tipping backward of the epiglottis which is further aggravated by the downward force of air passing from the wide laryngo-pharynx into the narrower glottis. This may result in the unattached part of the epiglottis being sucked through the glottis. There may also be anatomical variations in the epiglottis which make impaction more likely; the fact that impaction occurred twice in one patient would seem to bear this out.

Obstruction by the epiglottis may occur with no symptoms other than the cessation of respiration. The author’s treatment consists in opening the mouth with a gag and drawing the tongue well forward. The forefinger is then used for release of impaction by sliding it under the epiglottis from the side. The anatomy and physiology of the epiglottis were reviewed in this article.

It is believed by the author that many cases are missed because the condition is not looked for. Also, impaction is frequently relieved by the routine measures used for the relief of obstruction such as traction on the tongue, and artificial respiration. Possibly unexplained deaths in the operating room could have been prevented if this condition had been thought of. It is not looked for at autopsy and, furthermore, postmortem changes may alter the structural relationships.

N. B.