ABSTRACTS

Editorial Comment: A fixed style of presentation for this department of ANESTHESIOLOGY has purposely not been defined. It is the wish of the Editorial Board to provide our readers with the type of abstract they desire. Correspondence is invited offering suggestions in regard to the length of abstracts, character of them, and source of them. The Board will appreciate the cooperation of the membership of the Society in submitting abstracts of outstanding articles to be considered for publication.

ANNOTATIONS: *Crile's Contribution to Surgery.* Lancet, pp. 79–80 (Jan. 16) 1943.

"When consciousness is extinguished by an anaesthetic the mindless organism left on the operating table is still capable of responding to painful stimuli by reflexes through lower levels of the central nervous system; and the sum of these responses may be the condition of surgical shock. This conception we owe to Crile, whose death on Jan. 6 in Cleveland, Ohio, robs the world of a great surgeon. Following up his conception of shock at the time of the 1914–18 war, he set himself to abolish the harmful side-effects of operations. The apprehension of patients was allayed by preliminary sedation, they were anaesthetised with nitrous oxide, the least harmful anaesthetic then known, and all afferent impulses from the operation area to the central nervous system were cut off by the injection of local anaesthetics. Though his original technique was not wholly effective and successful, this conception of anoci-association, as he called it, continues to influence anaesthetists and surgeons to this day. After its enunciation in his book, *Surgical Shock and Shockless Operation*, the rough and ready hurried operating of previous days was revealed as crude, almost primitive.

"George Washington Crile was born in 1864 and graduated in 1877 at Wooster University, Ohio, where he was professor from 1890 to 1900; afterwards he held the surgical chair at Western Reserve University before helping to found the famous clinic in Cleveland in 1924. He served in the Porto Rican campaign of the Spanish-American War, and his experience there stood him in good stead during the last European War, when he served as a colonel and received decorations from all the Allies. The Crile clinic at Cleveland, which ranks among the first four in America, is known for the surgical treatment of exophthalmic goitre in which he was a pioneer. Patients came not only from America but from all parts of the world and his technical skill in this branch of surgery was outstanding. His interest in shock led him to the study of the suprarenals, and he was the first to advocate sympathectomy for hypertension. Whatever he touched—and his interests were very wide—he enriched. His dynamic personality was for many years a stimulus to the young surgeons who worked with him and who subsequently carried his teaching into other clinics; while visitors from abroad were caught by his enthusiasm, originality and insight. He leaves what few can hope to do—a lasting impression on surgical practice."

Received through the courtesy
of the Editor of *The Lancet*.

LEWIS, C. B.: *Anaesthesia for Laryngofissure.* Brit. M. J. 1: 162 (Feb. 6) 1943.

"In view of the growing popularity of surgical treatment of carcinoma of the larynx it is important that an adequate anaesthetic technique should be evolved. . . . The suggested method does away with the necessity for a tracheotomy and ensures post-operative haemostasis. . . . Premedication: omnopon ⅓ gr. and scopolamine $\frac{1}{150}$ gr. 1 hour before operation. Induction: anaesthesia is induced in the normal way with N_2O, O_2, and trilene, using a Boyle apparatus. When the patient is well into the third stage of anaesthesia a stiff gum-elastic intratracheal catheter, St. Bart's pattern, size 12–14, is passed through the larynx into the trachea under direct vision. Great care is taken to avoid the growth during this manoeuvre. The proximal end of the catheter is now connected to the machine and anaesthesia is maintained with O_2 and trilene. Owing to the small bore of the tube it is usually necessary to supplement the volume of oxygen reaching the lungs by gentle intermittent pressure on the rebreathing bag with the expiratory valve fairly tightly screwed down. . . . As soon as the incision has been made and the larynx opened the space between the catheter and the trachea is thoroughly packed off with narrow gauze, leaving one end emerging from the lower part of the wound. . . . The catheter is now found to lie in the posterior commissure of the larynx and usually interferes very little with the surgical procedure. . . . Anaesthesia is maintained as before with O_2 and trilene, aided by manual pressure on the rebreathing bag at each inspiration. Some of the gas percolates back through the packing in the trachea. As trilene is non-inflammable the diathermy may be used if necessary. . . .

"Following excision of the growth it is often very difficult to achieve perfect haemostasis. After removal of the tracheal packing and catheter the anaesthetist may play his part by passing a large-bore Magill tube, size 8–9, with inflatable cuff, through the nose and into the trachea under direct vision. When the cuff lies in the larynx it is inflated through the pilot tube until it occupies the lumen of the larynx and presses up against the field of operation. The laryngofissure is now sewn up, and the patient returns to the ward with a clear airway and a guarantee of haemostasis. . . . The intratracheal tube is left in position for 8 hours. During this time the patient is given morphine, and a little 2% decicaine solution is sprayed down the tube from time to time. . . . Eight hours after the operation the laryngeal cuff is deflated. After waiting a few minutes the patient is asked to cough. If blood is coughed up through the tube, then the cuff is re-inflated and the same procedure repeated in 2 hours. If no blood appears, then the tube is gently but firmly withdrawn."

J. C. M. C.

HUMBY, GRAHAM, AND HAWKSLEY, MARGARET: *A Universal Apparatus for Peroral Intratracheal Anaesthesia: with the Anaesthetist's Point of View.* Brit. M. J. 1: 317–318 (Mar. 13) 1943.

"Intratracheal anaesthesia for oral surgery is unsatisfactory, because there is no apparatus universally applicable to the wide variety of common operations. . . . It was upon 400 hare-lip and cleft-palate cases that the universal apparatus has been evolved. . . . The universal apparatus . . . is made in two sizes, for adults and children re-