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 anesthesiology. 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.

AN APPLIANCE TO FACILITATE THE ADMINISTRATION OF INTRAVENOUS ANESTHESIA BY CONTINUOUS DRIP

The administration of intravenous anesthesia by the continuous drip method is becoming more popular. Many appliances have been utilized. A convenient, easily assembled apparatus is illustrated in use in figure 1. It consists of an arm-syringe wooden stand. The arm board is 24 inches long and the board supporting the syringe is 18 inches high.

The appliance is assembled and put in use by placing the arm board of the stand under the mattress and patient. The arm of the patient is placed on a pillow on the arm board. The entire upper extremity is

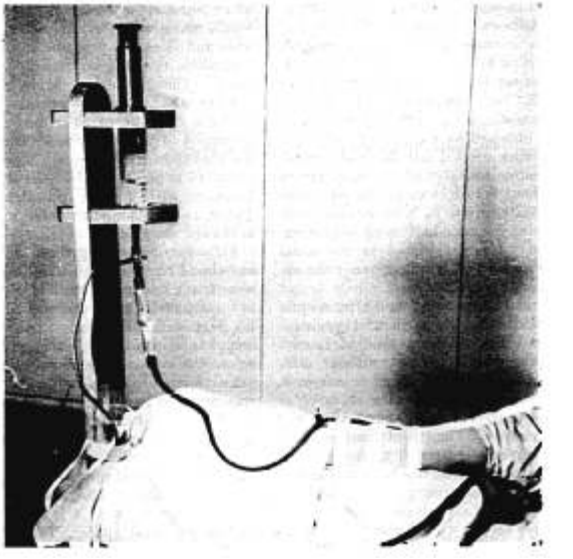

FIGURE 1.

secured by a bandage and elevated so that there is no back flow of blood in the rubber tubing. When this is done the anesthetist attaches the autoclaved parts of the apparatus. The barrel of a 50 cc. syringe is placed in its support and the remaining part connected to the barrel of the syringe. This consists of metal syringe adapter and a ¾ inch section of small rubber tubing which connects the adapter to a two-way valve; the other end of the valve is also connected with a ¾ inch section of small rubber tubing. A urethral catheter is attached to the other end of the two way valve for refilling the syringe whenever additional solution is required. The glass dripper is attached to the end of the rubber tubing already attached to the two way valve and connected with an 18-inch length of tubing which carries a glass needle adapter and a 20 gage needle. Sodium pentothal solution is placed in the syringe, the valve is opened to remove the air and then closed. The plunger of the syringe is put in place, the needle inserted into the vein and fixed with adhesive tape. The valve is opened and the amount of solution administered to meet the desired plane of anesthesia. Anesthesia is maintained by the continuous drip method of 1 per cent solution of sodium pentothal.

The author wishes to express his thanks for advice given by E. A. Rovenstine, M.D.

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CASE REPORT OF LOW TERMINATING DURA

A soldier, age 19, was admitted to the hospital October 19, 1943, with the chief complaint of pain in the back and right side of the abdomen. In August 1942 he had fallen on a stake placed in the ground, and had struck the right side of his back.

The patient was sent to surgery October 21, 1943, for cystoscopic examination. Routine anesthesia for cystoscopic examination was obtained by use of 35 cc. of 1 per cent procaine injected into the caudal canal. Premedication consisted of nembutal, grains 1½, one hour before examination, and morphine sulfate, grain ⅙, with atropine sulfate, grain 1/150, one-half hour before examination. He was placed in the usual prone position, with a pillow under the abdomen, for caudal anesthesia.

The caudal hiatus was found after aseptic preparation, and a 17 gage caudal needle inserted according to the method of Lundy. The needle was introduced without difficulty, and the depth of insertion measured by using the stilet and noting its level as compared to the external landmarks of the sacral foramina. The tip of the needle by this measurement extended to the level of the third sacral foramen. With the needle bevel down, aspiration was done and no blood or spinal fluid returned into the syringe. The needle was then rotated clockwise 90 degrees and aspiration done again, with no return. Five cubic centimeters of 1 per cent procaine was injected using a Luer-lok syringe. This was followed by another injection of 5 cc. of procaine. The needle was rotated 90 degrees further clockwise and 5 cc. of procaine injected after aspiration revealed no return of fluid or blood. The needle was again rotated 90 degrees and aspiration at this point revealed a free flow of clear fluid which was presumed to be spinal fluid. The depth of the caudal needle was again measured and found to be at the level of the third sacral foramen. No further procaine was injected, and the patient showed no signs of untoward reaction.

Fifteen minutes after the start of caudal anesthesia the patient noted that his legs were heavy and numb, but motor power was not completely lost. He was able to lift his legs with difficulty, although he had complete anesthesia of both legs extending up to the crest of the ilium. Cystoscopic examination was completed and the patient was returned to his bed in good condition. There was no indication forty-eight hours later of any anesthetic complication.

It is a common experience to anesthetists that aspiration will return but a few minims of fluid usually, and occasionally as much as 1 cc. when fluid is injected into the caudal peridural space. The return flow of this quantity of fluid with the tip of the needle in the peridural space is commonly