OROTRACHEAL ANESTHESIA FOR CHEILOPLASTY *

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CONGENITAL lip deformities are usually repaired when the child is from a few days to 6 months of age. The surgeon rightfully resents the presence of the anesthetist's hands or equipage in the surgical field. However, the loss of an infant on the operating table as a result of respiratory obstruction convinces the surgeon and the anesthetist that proper provision must be made for a free airway throughout the operation. This leads to the use of apparatus which assures efficient respiratory exchange while being "inconspicuous" in relation to the surgical field.

The use of orotracheal anesthesia in infants is ably described by Magill (1), Gillespie (2), Kaye (3), and others. The use of a by-pass or "T" tube attached to the orotracheal tube proves clumsy and the tube is often pushed aside by the surgeon. A small breathing bag and blow-off valve may be difficult to attach to the smallest sizes of endotracheal tubes. Being cumbersome, it may kink or extract the tube from the glottis when the head is moved. If the blow-off valve is not properly adjusted, enough carbon dioxide may accumulate in the system to initiate convulsive manifestations.

Figures 1*a* and 1*b* show a metal connector with a vent of the same diameter as the tube itself.† This connector fits a "O" or "OO" endotracheal tube. It is shaped to pass out of the corner of the mouth so that it occupies a position similar to that of an "ether hook." To the connector is attached the gas hose from the anesthesia machine, whereby a flow of oxygen and ether vapor is delivered to the patient. The vent is close to the end of the endotracheal tube, permitting the escape of exhaled and/or excess gases delivered from the source of supply. Since it is similar to the "T" tube, rebreathing is eliminated and excess gas pressures are avoided. To protect the infant's lungs from any sudden flow of gas at a high pressure, a pop-off valve is inserted in the delivery tube from the gas machine which blows off at 8 to 10 mm. of mercury.

Figures 2*a* and 2*b* show an anesthetized child with the orotracheal tube and connector in place.

* From the Department of Anesthesiology, University of Texas Medical School, Galveston.

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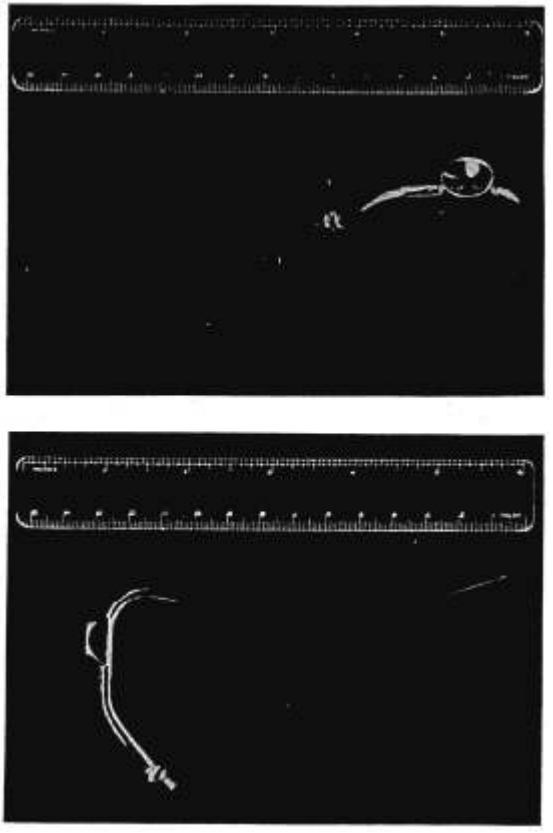
† The metal adapter described was made from angular finger valve for suction or inflation manufactured by The Foregger Co., Inc., reshaped to suit purpose.

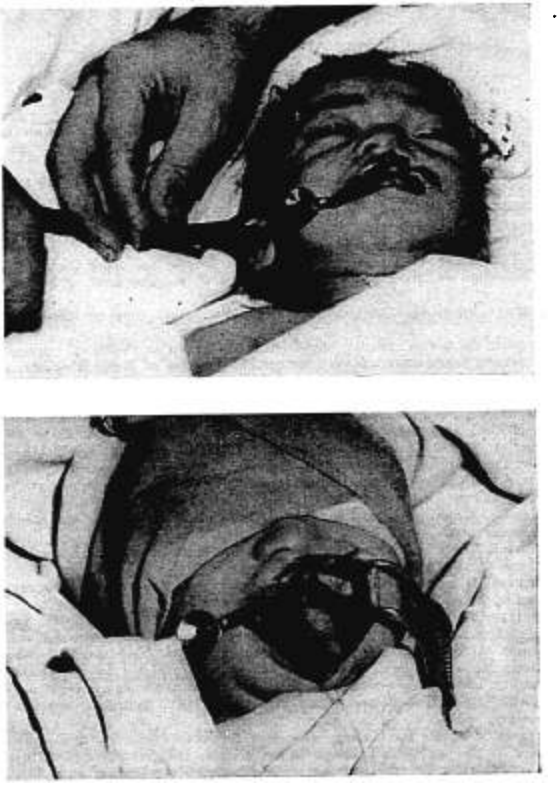
For the successful use of endotracheal anesthesia in infants, it is believed that a small amount of atropine or scopolamine should be



FIGS. 1*a* and *b*. Metal connector with a vent of the same diameter as the tube itself. This connector will fit a "O" or "OO" endotracheal tube.

used to diminish the output of mucus. To prevent the paroxysms of coughing and respiratory distress which may follow intubation, an effective degree of tissue saturation is produced by slow careful in-

duction with open drop ether. Oxygen is preferred as a vehicle for the ether vapor because many infants tend to show signs of circulatory embarrassment if a plane of anesthesia is produced which is sufficient to obtund all reflex irritability.



FIGS. 2*a* and *b*. An anesthetized child with the orotracheal tube and connector in place.

Orotracheal anesthesia for cheiloplasty by the method described has been responsible for much closer cooperation between the surgeon and the anesthetist in the accomplishment of a surgical procedure under difficult circumstances.

REFERENCES

1. Magill, J. W.: Technique in Endotracheal Anaesthesia, Brit. M. J. 2: 1, 1930.
2. Gillespie, N. A.: Endotracheal Anaesthesia in Infants, Brit. J. Anaesth. 17: 136 (Dec.) 1939.
3. Ayre, P.: Anaesthesia for Harelip and Cleft Palate Operations on Babies, Brit. J. Surg. 25: 131, 1937.

SOCIETY NEWS

Dr. Meyer Saklad, Chairman of the Committee on Clinical Records, has announced that the new codes and cards are now completed and ready for delivery. Inquiries regarding them should be directed to Headquarters' office.

Copies of the 1945 corrected edition of the Constitution and By-Laws are now available to those who send a stamped, self-addressed envelope.

The Booklet of Information of the Committee on Fellowship has been completely revised and also is ready for distribution. The Committee on Fellowship has reviewed all applications for fellowship and proposes to hold written and oral examinations in connection with the October and December meetings of the Society to be held in New York City.

The following resolution was made and passed at the last meeting of the Board of Directors:

"WHEREAS by common usage, the nurses assisting surgeons are designated surgical nurses, and

"WHEREAS the nurses assisting obstetricians are known as obstetrical nurses,

"THEREFORE BE IT RESOLVED that the present practice of designating nurses in anesthesia as nurse anesthetists be discontinued and, in the future, all American Society of Anesthesiologists' literature and communications refer to these as anesthesia or anesthetic nurses."

The following resolution, previously adopted by the Section on Anesthesiology of the American Medical Association, was presented and duly adopted by the House of Delegates of the American Medical Association on June 15, 1944. This resolution, which has also been endorsed by the Board of Directors of the American Society of Anesthesiologists, reads:

"WHEREAS, There has been introduced a variety of anesthetic drugs and methods during recent years; and

"WHEREAS, A more rapid and accurate method of evaluating these new anesthetic practices is desirable; and

"WHEREAS, There is accumulating evidence that misinformation exists concerning safe administration of anesthetic drugs; and

"WHEREAS, It has been demonstrated that anesthesia study commissions are of educational value to the medical profession; now therefore be it

"RESOLVED, That the American Medical Association should encourage the formation of anesthesia study commissions within the state, county, and other similar medical societies."

A Section of Anesthesia was approved by the Executive Committee and Council of the Massachusetts Medical Society. The initial officers are appointed by the president of the medical society, and subsequent officers will be elected at the annual section meeting. The appointed officers for 1945–46 are Sidney C. Wiggin, M.D., Chairman, and Leo V. Hand, M.D., Secretary.

Two types of service for binding volumes of ANESTHESIOLOGY are now available. The first of these is the one which has been in use prior to the present time and consists of a green buckram binding at $2.00 per volume or a yellow cloth binding at $1.50 per volume. Because the return of volumes to be bound under the above service has been time-consuming, a second type of service has been introduced, costing $3.50 per volume, which promises completion of the work within a few weeks. When volumes are sent to the A.S.A. office for binding, members are asked to specify the type of service desired.