

## URTICARIA FOLLOWING SODIUM PENTOTHAL ANESTHESIA

*Case Report:* In August, 1945, a white farmer, age 41, physical status 1, submitted to sodium pentothal intravenous anesthesia for thirty minutes to facilitate exodontia. The surgeon injected procaine with adrenalin, 1:15000, before operating. The procedure was uneventful and the patient recovered promptly without sequelae.

A month later, the remaining teeth were extracted during similar anesthesia, except that the infiltration of procaine-adrenalin was omitted. On this occasion shortly after intravenous sodium pentothal was started, marked urticaria was noted near the area of injection. At the completion of operation, 35 minutes later, many large-hive-like welts were discovered on the arms,

shoulders and chest. When returned to bed, urticaria was found to be generalized over the body. The patient was very restless and had severe itching which was controlled in some 45 minutes after adrenalin in oil was given subcutaneously. Recovery was uneventful.

Urticaria resulted from sodium pentothal given for a second operation. It had been averted when the same drug was given one month earlier to the same patient who, on that occasion, had received an injection of adrenalin.

ALVIN C. KNAUSS, M.S., Ph.D.,  
*Carle Hospital Clinic,*  
*Urbana, Ill.*

## CORRESPONDENCE

*To the Editor:*

Major Stein's article in the September, 1945, issue of ANESTHESIOLOGY, which described a case of allergy to ether, was most interesting. It is apparently true that the patient has a true sensitivity to ether, but the evidence is not conclusive that this sensitivity caused the circulatory depression. There is a definite possibility that the morphine may have contributed to the circulatory deficiency, as pointed out by Dripps and Comroe in an article on that subject in the same issue. In both anesthetics the morphine was administered at such a time that the development of its maximum effect and the development of the depression of circulation were concur-

rent. That the fall in blood pressure was less marked in the second anesthesia may have been due to the fact that the primary shock was treated correctly with a vasopressor drug, whereas such a drug was not used during the first anesthesia.

It is of interest also to note that in the conduct of the Prausnitz-Kustner test there is no evidence to indicate that the normal subject was tested with ether prior to the intradermal injection of the allergen.

Very truly yours,

STUART C. CULLEN, M.D.,  
*Ass't Prof. of Surgery (Anes.),*  
*State University of Iowa,*  
*Iowa City, Iowa*

*To the Editor:*

I have just read the review of Nitrous Oxide-Oxygen Anesthesia by F. W. Clement which was published in the November issue of ANESTHESIOLOGY, written by Dr. Everett A. Tyler. The acceptance of the use of primary and secondary saturation, which is clearly stated by Dr. Clement in his book to be the administration of pure nitrous oxide, seems to me to represent an uncritical and unphysiological point of view. It is difficult not to be astounded by a recommendation for the use of asphyxia as a therapeutic agent. The danger of anoxia in nitrous oxide anesthesia which Dr. Rovenstine and I discussed in the last issue of this Journal seems to me to be in essence ignored both in Dr.

Clement's book and by the reviewer. Dr. Tyler says: "He discusses the primary and secondary saturation technic of McKesson, but limits its use to highly trained anesthetists." It is to my mind a procedure of peril to recommend to *anyone* the administration of pure nitrous oxide without oxygen. The studies of Courville of themselves are adequate evidence that physiological anesthesia should dispense with deliberate deprivation of oxygen to the human brain under any circumstances.

Very truly yours,

ALVAN L. BARACH, M.D.  
*Columbia University,*  
*College of Physicians and Surgeons,*  
*New York, N. Y.*