and discarded, and the theory of respiratory depression or even obstruction after an overdose of sedative drugs had no basis in fact. The suggestion of a delayed reaction to nupercaine was made, but could not be considered seriously.

Later investigation revealed that, in error, the patient had received 0.5 mg. of prostigmine hypodermically after his return to the ward, and a similar dose half an hour later. The intention was to administer this drug if the patient did not void after eight hours, but the order was written prematurely and by mistake the drug was given at once. Although five hours had elapsed since the spinal anaesthetic agent had been injected, the effects were still marked enough to influence the patient's reaction to prostigmine. Ordinarily, no systemic reactions are evoked, but in this individual the results were striking, presenting a text-book picture:*

*The symptoms and signs of poisoning by physostigmine and prostigmine are sufficiently similar to allow a single description to suffice for both drugs. Poisoning from these alkaloids usually occurs accidentally in medical practice. Symptoms come on quickly after ingestion of the drug and soon reach their peak. The effects on the bowel are as a rule first to be noted and violent peristalsis, nausea, vomiting, colic, persistent purging and vomiting occur. The skeletal muscle phenomena consist of fibrillary twitchings all over the body, nystagmus and dysarthria. Restlessness and weakness are prominent. The pupils are pin-point in size and distant objects are blurred. Sweating, salivation and lacrimation may be marked. Dyspnea is present due to bronchiolar constriction and abundant pulmonary secretions. There is urinary urgency and difficulty in voiding. The skin is ashen-gray in color and bathed in a cold perspiration. The heart rate is rapid, the pulse weak and the blood pressure at shock level. Consciousness is not disturbed except for faintness and the fear of impending disaster. A fatal outcome is usually caused either by pulmonary edema or central respiratory paralysis. Death may occur within one-half to two hours after symptoms are first noted.*

"Treatment consists of hypodermic or intravenous administration of one to two mg. of atropine sulfate, dependent upon the urgency of the case. Atropine quickly counteracts the serious effects of physostigmine, namely, those on the lungs and circulation, but it does not influence the annoying but innocuous skeletal muscle twitchings. These subside as the drug is eliminated from the body."

This case is reported as a matter of interest to anaesthetists because of the present widespread use of curare. The drug employed as the pharmacologic antidote to curare is physostigmine. This might occasionally produce symptoms of poisoning, for which the treatment is simple and effective, once the diagnosis is made.

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DOUBLE TIER ARM SUPPORT

There are many problems which confront the anaesthesiologist during the course of anesthesia, one of which is the patient's position on the table with reference to the anesthetic and the patient's comfort. Herein is presented a double tiered arm board which has been satisfactory for support of the arms during operation when the patient is in the lateral position. The construction of the arm board is such that it tends to keep the arms apart and in turn prevents the compression of the chest by supporting the weight of the upper arm. When the arms are supported the veins are easily accessible for intravenous therapy. During the course of thoracic operations it is often necessary to apply traction to the upper arm. This is facilitated by applying a well-padded wrist traction with a small weight extending over the end of the upper board. The board is constructed without padding so that folded sheets may
be inserted to meet the requirements of each individual case.

The dimensions are as follows: ½ inch plywood for the upper and lower arm boards. The boards are 6½ inches wide, the upper board 34 inches long and the lower board 36 inches long. The boards are kept apart by four ½ inch round wooden supports 14 inches long. The supports are dowelled at the outermost end and at a distance 14 inches from that end. The added length of the lower board allows it to be placed between the mattress and operating table, assuring a firm support.

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