
In analyzing the operative deaths at Children’s Hospital [Washington, D. C.] during a five year period the cases were divided into three groups: 1. Those deaths probably due to the anesthetic; 2. those probably not due to the anesthetic and, 3. those which occurred during intracranial surgery. Each death is studied from clinical aspects as well as the pathological report, discussion of the probable mechanism of death and methods for preventing the recurrence of similar accidents. In those deaths which occurred during intracranial or extra cranial surgery it is difficult to say whether the death was due to the anesthesia, wholly, in part, or at all. During the five year period, 1941–1945 there were 17 deaths under anesthesia. Of these, 6 were classified as probably due to the anesthesia, 4 were probably not due to the anesthesia and 7 occurred during some form of intracranial surgery. In the 6 cases classified as anesthetic deaths five factors were presented as etiological factors: “1. Failure to aspirate gastric contents in 2 cases of intestinal obstruction; 2. Overdose of the induction agent in a crying, apprehensive child; 3. Misdiagnosis of rheumatic abdominal pain for an ‘acute abdomen’; 4. Failure to discern signs of atelectasis during the operative procedure; 5. Administration of ether and a blood transfusion simultaneously to a child with an oclued intraventricular system.” In intracranial surgery three suggestions were made for improving the anesthesia technic: “1. Substitution of ethylene oxide or nitrous oxide as the anesthetic agent in place of ether; 2. Periodic recordings of the vicissitudes of blood pressure, pulse rate, and respiratory rate every 15 minutes; 3. Adequate anti-shock measures at the first signs of collapse.” 14 references.

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Only recently have anesthetists and manufacturers of gas machines been cognizant of the physiological differences in children and adults. The difficulty of appraising the child’s physical condition for anesthesia is greater. Tribromethanol and the barbiturates, except pentothal sodium, are preferred by the author to morphine and atropine for premedication in young children. Pentothal is not recommended for children under 10 years of age for several reasons. The respiratory depression in children is out of proportion to the abolition of reflexes. The maintenance of an even plane of anesthesia is difficult in children. The amount of pentothal is greatly out of proportion to the weight of a child. Children may not tolerate venipuncture, relaxation may not be adequate in spite of depressant amounts of the drug. Broncho-constriction caused by pentothal becomes much more important in children. Nationwide reports show that the mortality rate in the use of sodium pentothal for children is high.

A closed, unidirectional, circular, absorptive type gas machine is preferred by the author to the to-and-fro type. Intubation decreases the mechanical and physiological dead space, eliminates the bad effect of malposition of the head and neck, allows free exchange of gases, aids insufflation of the lungs, and removes the anesthetist from the field of operation. Excess secretions can be aspirated from the trachea through the tube. The age and size of the child may affect the deci-
SION AS TO THE USE OF INTRATRACHEAL INTUBATION.

Spinal analgesia has been used in certain cases. The dosage of 1 mg. of procaine per pound of body weight has been adequate in the author's experience. In children under 3 years of age, open drop ethyl ether anesthesia is best from the standpoint of potency and safety. The optimum psychic state is desirable. Induction of anesthesia should be uneventful and should not precipitate terrorizing memories. Some children, old enough to understand, may benefit by an explanation of the anesthetic process. Darkness, restraint and the smell of ether are three troublesome features of induction of anesthesia in children. The shield should not be placed over the eyes. Nitrous oxide, allowed to flow over the face without placing the mask tightly on the face, may bring about anesthesia without inducing fear. Attention to small details and proper premedication when necessary will minimize psychic trauma.

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The opinion given by an internist concerning the risk of anesthesia and a surgical procedure in a patient who has organic heart disease is based on the answers to several implied questions. '1. Will the anesthesia and surgical operation increase the demands upon the heart beyond the limits of the cardiac reserve and therefore precipitate congestive heart failure? 2. Does the heart require treatment before operation? 3. Is the prognosis of the heart condition so grave that operation should be avoided if possible or limited to an emergency or palliative procedure? 4. Is the heart condition such that it carries with it the liability to sudden death during anesthesia and surgery? 5. What bearing does the state of the heart have on the choice of the anesthetic? 6. What, if any, cardiovascular complications are to be anticipated during the operation and postoperative period?' The answers to these questions usually can be obtained from the clinical history and from the physical examination. As a rule, with few exceptions, patients with heart disease who have been able to carry on normal daily activities without experiencing symptoms of coronary or myocardial insufficiency can tolerate general anesthesia and surgery with no more risk than a normal person.

Careful questioning as to the occurrence of dyspnea or substernal pain on effort is more important than are cardiac findings on physical examination. An abnormal electrocardiogram in a patient who has been able to carry on normal activities usually does not indicate an increased risk from surgery and anesthesia. A period of preoperative treatment is advisable in pa-


Fear of cystoscopic examination persists in the minds of patients. This fear sometimes results in postponing the examination. Reassuring the patient, avoiding the use of the word cystoscopy, careful selection of instruments and skillful handling of instruments may help in overcoming fear. In the female introducing a small caliber cystoscope is, as a rule, no problem. In the male a local anesthetic should be injected into the urethra. General anesthesia is used for cystoscopy if catheterization is intolerable to the patient. 2 references.

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