distances involved in order to arrive at a more precise understanding of the problem. . . . After measurement of 200 adult skulls, 149 with teeth in normal occlusion and the remainder in malocclusion, it was found that the distance from the inferior orbital fissure to the dento-enamel junction of the second molar, hereafter referred to as the ‘needle distance,’ varied from 29 to 51 mm. If it is now considered that the distance from the gingival margin to the buccal fold may vary from 3 to 12 mm., one realizes the problem inherent in using a fixed depth of injection, whether it be 2, 2.5, or 4 cm. . . . The two variable distances, the height of the buccal fold and the needle distance, negate the value of any fixed depth of injection. In the course of our study on these skulls we found a close relation between the distances from the inferior orbital fissure to the dento-enamel junction of the second molar (needle distance) and the distance from the infra-orbital margin to the dento-enamel junction of the bicuspids, hereafter referred to as the ‘facial measurement.’ . . . Clinically, it is possible to measure the facial distance with a caliper, applying one point to the infra-orbital margin and the other to the gingival margin of the second bicuspid. The distance then is marked off on the 20 gage bent hypodermic needle with a movable rubber stop, and the insertion is made until this is opposite the gingival margin of the second molar. Using this method on a large number of patients, we have obtained excellent results.”

J. C. M. C.


“Vesalius in 1542 discovered that inflation of the lungs was necessary to life when the chest was widely opened. He was able to keep animals alive under these conditions by blowing intermittently into a reed inserted into their tracheas. . . . The first really exhaustive study in endotracheal anesthesia was made by the German surgeon, Franz Kühn. Kühn devised semi-rigid metal tubes which he passed into the trachea either through the nose or through the mouth, using a finger to guide the tube through the larynx. . . . In 1909, Meltzer and Auer showed that if air under some positive pressure were blown into the trachea at its bifurcation, life could be maintained in an animal whose respiratory movements had been suppressed by curare. An endotracheal catheter of narrow hose was used, and the air was allowed to escape between the tube and the trachea. The degree to which the lungs were kept distended obviously depended on the relation between the rate at which air entered through the catheter and the rate at which it could escape through the glottis alongside the catheter. This technique was applied to clinical anesthesia by Elsberg, and has come to be known as ‘insufflation endotracheal anesthesia.’ . . . The ingenuity of such men as McKesson, Gwathney, Teter, Foregger, and Connell in this country, and of Bayle, Shipway, Magill, and Rawbotham in England was displayed as they evolved apparatus for the administration of vapors and gases. . . . It is to the records which will be kept in the future by the rising generation of anesthetists that we must look for evidence which will enable us to form a more balanced judgment as to the optimum conduct of anesthesia for thoracic surgery.”

J. C. M. C.


“The opening of an abscess is usually an office procedure. . . . The ex-
pert in the treatment of rectal diseases by office methods will use local anesthesia, in the form of monocaïne, nun-}
{percaïne, novocaïne, or whatever local anesthetic is the choice of the operator. . . . Before doing anything else we}
{should mark what looks like the spot where this abscess would head up if permitted to do so. . . . It is even a}
good idea to mark the lines of the incision which we intend to make after anesthesia is established. . . . The in-
jection of the local anesthetic should be begun at a point about two inches away from the center of the site of
incision. After the area is cleaned, a spot should be made on the skin with carbolic acid (phenol 35 per cent), on
a wood applicator rather than with a metal probe. The wood will soak up some of the solution and make a dis-
creet spot. When this small spot is made on the skin, the needle is then inserted into the very superficial layers
of the skin. . . . Injecting as we go, the needle should be advanced with the idea of forming a complete ring of
injected skin around the summit of the abscess. . . . The objections expressed condemning local anesthesia near ab-
seses are based on the theory that we are likely to spread the infection or get it into the blood stream. This idea
got into a book and so will be found in all books henceforth.”

J. C. M. C.

Brown, A. S., and Howrie, J.: Per-
caïne as a Cocaine Substitute. J.
Laryng. and Otol. 62: 96–99 (Feb.)
1948.

“When using cocaine solutions dur-
ing anaesthesia a drug reaction occurs,
in spite of all reasonable precautions,
in a small but significant number of
cases. . . . In an endeavour to overcome
this danger it was decided to try to
find a safe substitute for cocaine from
among the drugs at our disposal in
Japan and, if such a drug was avail-
able, to discard cocaine entirely. On
consideration it was known that per-
caïne (B.P.) is an efficient surface an-
esthetic in concentrations of 2 per
cent., having a good action on mucous
surfaces, and from experience in its
use in spinal and local anaesthesia, it
was known to be a safe drug. Also,
as far as could be found from the lit-
erature available to the authors, no
cases of idiosyncrasy to the drug have
been reported since its introduction.
. . . The otolaryngologist was ap-
proached with a view to doing a con-
trolled series of experiments, using the
1:200 solution of percaïne in 6 per
cent. glucose as a direct substitute for
cocaine. . . . The authors have carried
out a clinical trial on a series of over
fifty assorted cases using the standard
(1/2 per cent. percaïne in 6 per cent.
glucose) heavy spinal anaesthetic solu-
tion and have found it to be quite as
good as 10 per cent. solutions of cocaine
in every respect except one, namely
that it does not provide deep vasocon-
striction of the tissues. However, the
surgeon (J. H.) never found this to
be more than a minor inconvenience.
. . . The period of anaesthesia is about
an hour and a half’s duration and so
avoids the necessity of ‘working to the
clock’ during lists. The long period of
analgesia following its use makes the
initial period of recovery much more
pleasant for the patient. Its action is
very rapid even in the presence of se-
vere haemorrhage, thus giving it an
advantage where intranasal packs have
to be inserted in an emergency. The
cough and laryngeal reflexes return
within forty minutes. . . . The authors
have discontinued the use of cocaine
solutions for all purposes and substi-
tuted the 1:200 solution of percaïne
in 6 per cent. glucose, for all ear, nose
and throat work, as they regard the
use of cocaine as no longer justified
in the presence of an equally efficient
and much safer drug.”

J. C. M. C.