

PROTECTIVE SHIELD FOR CONTINUOUS SPINAL NEEDLE *

In operations of long duration under continuous spinal anesthesia by the needle technic, when the patient is to be operated upon in any position other than the supine, a frequent complication is that the needle may move out of place. This is even more

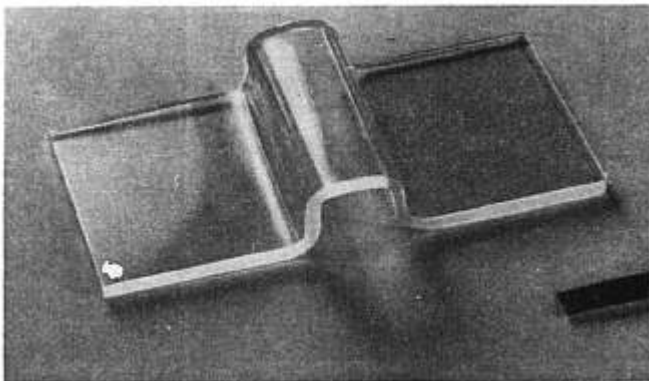


FIG. 1. Protective shield.

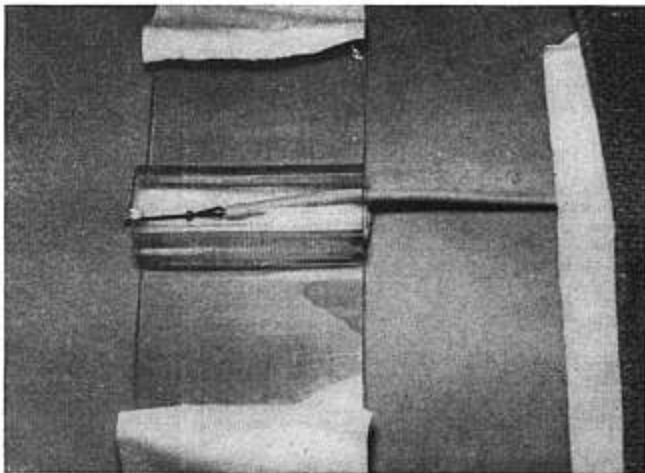


FIG. 2. Protective shield in position over lumbar vertebrae.

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likely to occur in spine fusions, nailings of the hip and similar procedures when surgical procedures are done in close proximity to the spinal needle.

This disadvantage could be eliminated by administration of a long lasting "single dose" spinal anesthetic agent, or by the continuous catheter technic, but these procedures either may not be indicated or the equipment may not be available. A simple device effectively prevents dislodging the spinal needle if needle technic is chosen:

The malleable needle is inserted as usual. The needle is bent sharply at the skin edge. It is secured by holding it with forceps close to the skin. The needle is held in its position by padding it with gauze and then covering it with a protective shield taped

to the patient's back. This shield is made of plexiglass, 7 by 14 cm. in size, and 0.5 cm. thick. It is bent so that a channel is formed deep enough to provide adequate space for the needle.

Self-retaining retractors may be placed above this shield so that traumatic manipulations can be performed without disturbance of the continuous spinal apparatus with this technic. We have employed the method successfully in 27 consecutive cases.

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To the Editor:

Dramamine is being used empirically in a variety of conditions which are accompanied by nausea. Since there is a possibility that it may have a direct effect on the vomiting center, we have tried the drug as a preoperative medicant in order to study its influence on the occurrence of nausea and vomiting following operation. So far it has been employed in 100 consecutive cases in which major surgical procedures were performed under cyclopropane anesthesia, in most instances with sodium pentothal induction, a few with the addition of ether. Cases in which other types of anesthesia were used were omitted from the series. One hundred comparable cases were observed as controls.

An exact evaluation of the results is extremely difficult and a much larger number of patients must be treated to prove whether or not the impressions gained so far are consistent. Only an extended period of observation would justify disregarding the large number of variables, such as age and sex of the patient, individual disposition, the particular illness, type and duration of the operation, the influence of other drugs and so forth.

Doses of dramamine given were 100 to 200 mg. one to two hours before operation. Results seemed to improve with the larger amount which, in addition, produces marked sedation without undue depression. Possibly even larger doses should be used. It appears, however, that postoperative rectal medication with 200 mg., as suggested by Dr. Peterson in the November 1949 issue of *ANESTHESIOLOGY*, is more effective.

The incidence of postoperative nausea and vomiting is definitely decreased after administration of dramamine, although not dramatically so. In our series, 48 per cent of the premedicated patients were entirely free of nausea and vomiting as compared with 42 per cent of the control series. Nausea and vomiting occurred in 17 per cent of the premedicated cases and in 29 per cent of the controls. The remainder of the patients were classified somewhere in between when they exhibited only slight or transient nausea. Quite a few patients denied having any nausea although they had to regurgitate fluids or food which they took within about eight hours after operation. They were comfortable after emptying the ingested ma-