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FRANCIS F. FOLDES, M.D.,
AND PEARL G. MCNALL, M.D.,
*Department of Anesthesia,
Mercy Hospital,
Pittsburgh, Pa.,*
and
*Section on Anesthesiology,
Department of Surgery,
University of Pittsburgh,
School of Medicine,
Pittsburgh, Pa.*

UNUSUAL COMPLICATION OF NASAL INTUBATION: REPORT OF CASE

A markedly obese woman, 61 years old, was admitted to the hospital for a hemorrhoidectomy. The patient was adamant in her refusal of spinal or caudal analgesia as was the surgeon in his demand for the Buie position. Confronted with this undesirable combination, I selected an endotracheal technique as the method of choice. Since the patient was of short-necked type in whom it is usually easy to perform intubation blindly by the nasal route, this approach was chosen.

Anesthesia was induced, using a cyclopropane-ether sequence. Partial obstruction commenced simultaneously with loss of consciousness, and required early introduction of an oropharyngeal airway. When the patient was in the second plane of surgical anesthesia, an attempt was made to pass a number 30 French Magill endotracheal tube into the right nostril. Some resistance was encountered, so the left side was tried. However, this side seemed completely impassable, so the right side was employed. A slight degree of resistance was encountered when the tube was passed but, after insertion, no breath sounds were audible at the proximal end of the tube although the patient was respiring freely.

Because of the fear that a foreign body might have been encountered during passage of the tube, with subsequent occlusion

of its lumen, or that the tube had entered the esophagus, direct laryngoscopy was resorted to with the tube still in place.

No foreign body, mucus or blood was seen in the pharynx and larynx, but the endotracheal tube could not be visualized. Just to the right of the midline, however, the mucous membrane of the posterior pharyngeal wall bulged. With manipulation of the tube, this bulge was seen to advance and recede with insertion and withdrawal of the tube. At no place in the region under observation was any rent detected in the mucous membrane.

The tube was removed and orotracheal intubation was contemplated when the surgeon, sensing some difficulty with the conduction of the anesthesia, volunteered to carry out the surgical procedure with the patient in the lithotomy position.

It is postulated that the endotracheal tube dissected beneath the mucous membrane at the mucocutaneous junction shortly after it entered the right nostril.

After operation, the patient was not interrogated specifically about nasal or pharyngeal discomfort and, strangely enough, complained of none.

WILLIAM M. DALY, M.D.,
*Rochester General Hospital,
Rochester 8, N. Y.*