CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a section in ANESTHESIOLOGY in which will appear invited and unsolicited professional and scientific correspondence, abbreviated reports of interesting cases, material of interest to anesthesiologists reprinted from varied sources, brief descriptions of apparatus and appliances, technical suggestions, and short citations of experiences with drugs and methods in anesthesiology. Contributions are urgently solicited. Editorial discretion is reserved in selecting and preparing those published. The author's name or initials will appear with all items included.

PALATAL EXPIRATORY OBSTRUCTION

While using the sequence of muscle relaxing agent pentothal-oxygen insufflation (1) before performing tracheal intubation, it has been noted in about one-third of the cases that although it is easy to inflate the lungs, expiration is completely obstructed. With full muscular relaxation, apparently the soft palate drops back on to the nasopharynx and, in many patients, completely obstructs expiration through the nose. Inspiration is unobstructed, however, owing to the simple valve-like movement of the soft palate. The maneuver of holding up the chin and fitting the face mask usually closes the mouth so that the apparent paradox of a clear airway for inspiration and a completely obstructed airway for expiration occurs. When attempts at artificial respiration, with the mouth closed, are continued, the lungs distend more and more so that insufflation meets increasing resistance and the impression is gained of complete respiratory obstruction. Opening the mouth, however, allows easy and complete expiration, after which the lungs may easily be inflated again.

With the patient apneic and the respiration obstructed, there is a natural attempt to correct the situation with a hurried and perhaps panicky intubation, or perhaps with the insertion of an oral or nasal airway, any of which will solve the problem. However, if the mechanism involved is understood, the anesthesiologist can insufflate with oxygen for as long as desired simply by allowing the mouth to open for expiration after each insufflation, following which intubation may be performed leisurely.

There may be circumstances in which the above mechanism might assume more importance, for example, in electric shock therapy and carbon monoxide poisoning, especially if it is not understood and airways are not readily available. Also, continued efforts at insufflation against what appears to be an obstructed airway could conceivably rupture some alveoli.

An understanding of the above mechanism has saved me some unnecessary anxiety.

F. A. WALTON, M.D.,
Royal Columbian Hospital,
P. O. Box 478,
New Westminster, B. C.

REFERENCE

1. Walton, F. A.: Flaxedil, New Curarizing Agent, Canad. M. A. J. 63: 123–129 (Aug.) 1950.

HEXYLCAINE *—A NEW TOPICAL ANESTHETIC AGENT

Topical anesthesia is frequently employed in peroral endoscopic procedures because of greater convenience and the belief that this method is safer than the various types of general anesthesia. However, reactions from local anesthetic drugs occur relatively often and not infrequently are fatal.

The two drugs most generally employed in topical anesthesia are cocaine and pontocaine®. Reactions which occur when the former is utilized may result fatally. When

* Cyclohexylamino-2-Propylbenzoate.