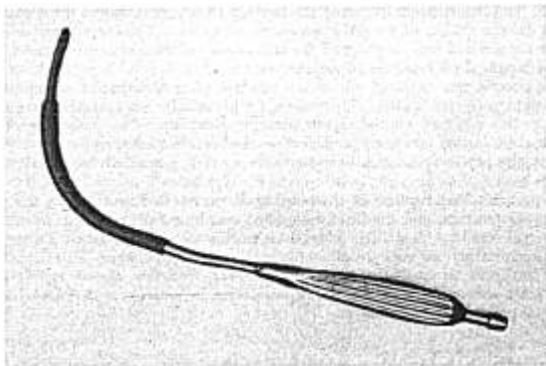


He has found this tracheal sucker to be especially helpful during tonsillectomy surgery done with insufflation anesthesia. Aspiration of blood and mucus during tonsillectomy with this technique of anesthesia is almost inevitable. When it occurs to excess, the anesthetist can suck out the material in a moment rather than being tempted to wait for the end of the procedure or being forced to insert an endotracheal tube.



Tracheal sucker.

CASE REPORT: RUPTURE OF ESOPHAGEAL VARICES

Dr. Norman A. Bergman of the Presbyterian Hospital, New York, reports a case of rupture of esophageal varices.

A 55-year-old, thin, white man had been treated for bladder carcinoma for 24 years by transurethral resections and several courses of radiation therapy. He was admitted to the hospital in acute urinary retention owing to blood clots after a three week period of hematuria. On admission there were no physical abnormalities not related to the bladder disease. Hemoglobin was 6.8 Gm. per cent and prothrombin time was 19 seconds (normal control 15 seconds) and platelets were slightly decreased. During the next three weeks 9,500 cc. of blood were given. Two attempts to stop the hematuria by transurethral resection failed. One of these procedures was performed during spinal anesthesia and one during nitrous oxide oxygen and thiopental; both were uneventful.

It was therefore proposed to attempt to control the bleeding through a cystotomy. One hour after premedication with 5 mg. of morphine and 0.4 mg. of scopolamine intramuscularly, anesthesia was begun with 0.150 Gm. thiopental and 75 per cent nitrous oxide—25 per cent oxygen by semiclosed technique with a carbon dioxide absorber in the circle system.

Because of a moderate degree of pharyngeal airway obstruction which developed gradually, another 0.150 Gm. thiopental was administered, and a medium plastic oropharyngeal airway was inserted with ease. The patient reacted to the airway with a slight cough, and then regular unobstructed respiration was resumed. About three minutes later complete respiratory obstruction occurred, manifested by marked chest retraction on inspiration and failure of the anesthetic bag to move. Because the lungs could not be inflated in spite of vigorous chin support, 6 mg. of *d*-tubocurarine were administered. On subsequent attempts to inflate the chest blood began to seep out around the edge of the mask. The mask was removed and both bright red blood and dark blood

with clots poured out of the patient's mouth. In spite of vigorous aspiration of the pharynx alternating with attempts to inflate the lungs with oxygen by mask, a long but undetermined interval occurred before the pharynx was clear enough for visualization of the glottic opening. During this interval the blood pressure which had been stable at 90/70 became unobtainable, and the pulse became imperceptible. A large blood clot which was impacted in the glottis was removed with a clamp, and an endotracheal tube was passed, and immediate inflation of the lungs with oxygen restored the blood pressure to 130/75 and the quality of the pulse improved markedly. The operation was completed rapidly and aspiration bronchoscopy at the termination of anesthesia produced a moderate amount of bloody fluid from the bronchial tree.

Consciousness was regained within ten minutes after termination of anesthesia and the vital signs remained stable. There were no immediate postoperative complications; however, ascites occurred on the eighth postoperative day. The patient gradually became somnolent, lapsed into coma, and died on the fortieth postoperative day. Pertinent findings at autopsy were hemachromatosis with marked portal cirrhosis and esophageal varices.

It is probable that rupture of the esophageal varices occurred during the period of respiratory obstruction, and the brief episode of coughing following the insertion of the oropharyngeal airway. A sudden increase in intra-abdominal pressure is recognized as a factor precipitating the rupture of esophageal varices (Spellberg, M.: *Diseases of the Liver*. New York, Grune & Stratton, Inc., 1954). For this reason avoidance of increase in intra-abdominal pressure during anesthesia in patients with known esophageal varices is of paramount importance.

CORRESPONDENCE

WILLIAM THOMAS GREEN MORTON

To the Editor.—"Vanity, all is vanity. . . ."

"Dentistry" enjoys basking in the reflected honor and prestige accorded William Thomas Green Morton, "whose labors in introducing the anesthetic process into surgical operations have given him an eminent place among the benefactors of the human race."

Dr. Betcher's and your attention is respectfully called to an error in reporting by the *New York Tribune*, July 17, 1868. (Betcher, A. M.: *A Ride Through Central Park* [Editorial], *ANESTHESIOLOGY* 18: 785 [Sept.-Oct.] 1957.)

ORLAN K. BULLARD, D.D.S.
San Diego, California

To the Editor.—I am in receipt of Dr. Bullard's recent letter in which he calls attention to an error in reporting by the *New York Tribune*, July 17, 1868. I assume he refers to the final sentence in which Morton is called a Doctor of Medicine.

It is true that at the time of his demonstration at the Massachusetts General Hospital, October 16, 1846, he was referred to in the *Boston Daily Journal* of the next day as, Dr. Morton, Dentist. Also, in Jacob Bigelow's letter to Francis Boott of London of November 28, 1846, he stated, "The inventor is Dr. Morton, a dentist of this city. . . ." In this same year, Morton issued a circular to "Surgeons and Physicians" announcing his competency in administering "his compound to patients who are to have surgical operations performed," and signed it W. T. G. Morton, Dentist.

However, if we search further, we discover that by 1850, he had published two papers with a different signature: "Comparative Value of Sulphuric Ether and Chloroform,"