

CASE REPORTS

CONTINUOUS SPINAL ANESTHESIA IN TREATMENT OF ACUTE PULMONARY EDEMA

Dr. Herbert Ebner reports on the successful use of continuous spinal anesthesia in the treatment of acute pulmonary edema.

A 44 year old gravida VII para VI was admitted to the hospital October 15, 1956. Her expected date of confinement was November 24, 1956. She had a history of "heart trouble" dating back to 1939. Her hospital records showed that at that time she was found to have "a loud crescendo pre-systolic and systolic murmur at the apex and a history of chorea." The impression at that time was "probably early mitral heart disease." On this admission the patient was extremely dyspneic, orthopneic and anxious. Her temperature was 99.2, pulse 130, respiration 40, and blood pressure 190/100. Her right chest was resonant with scattered rales in the parasternal area and right base. The left chest had moist rales in the axilla and lower anterior half of this field. The heart was enlarged and there was a systolic grade III murmur at the apex and to the left of the sternum. The radiologist's report stated, "pulmonary edema." The clinical impression was (1) preeclampsia (2) congestive heart failure and pulmonary edema.

As he had been using fractional spinal anesthesia for the treatment of severe preeclampsia and eclampsia at the Providence Lying-In Hospital over a four year period with very gratifying results, he felt that this case would respond particularly well to this method of treatment. At 10:00 p.m. her vital signs were as on admission and reported above. Continuous spinal anesthesia was initiated with 1 cc. of 0.15 per cent Pontocaine intrathecally. The level of sensory blockade extended to the sixth thoracic segment. At 10:05 p.m. her blood pressure was 130/90, pulse 100 and respirations 25 per minute. She exhibited much less anxiety, the dyspnea had disappeared and she stated voluntarily that she was much more comfortable. At 10:15 p.m., fifteen minutes after the institution of the block, her B.P. was 130/90, pulse 90 and respiration 26 per minute. Examination of her chest showed that in this short interval of time her lung fields were clear of rales and adventitious sounds. The Tuohy catheter was left in the subarachnoid space for the next 14 hours but no further injections were needed and the patient's subsequent hospital course was uneventful.

Dr. Ebner reports this case because he feels that it is a therapeutic approach to pulmonary edema that is too often overlooked in spite of well established evidence of its efficiency. He feels, also that some are discouraged by the hypotension associated with "one shot" spinal. He suggests that by using the continuous or fractional technique, which allows small intermittent doses of the local anesthetic agent to be administered, a more controllable method is available. In addition, the block can be maintained for as long a period of time as necessary.

OCCLUSION OF ENDOTRACHEAL TUBE WITH FOREIGN BODY

Dr. D. H. Haselhuhn, of Harrisburg, Penna., reports that a 34 year old woman, scheduled for a cholecystectomy, was given an induction with sodium pentothal drip, succinylcholine for relaxation, and oxygen. Intubation with a number nine Davol tube was performed with ease. Attempts to ventilate the patient following intubation were met with a "stone-wall" resistance. The larynx was reexposed and the endotracheal tube was found to be in the proper location. Nevertheless, repeated attempts to ventilate the patient were unsuccessful and the tube was removed. The patient immediately began to breathe freely and easily. The patient was then intubated with ease with another endotracheal tube, and the operation and anesthesia were uneventful.

Examination of the first tube showed that there was a foreign body present in the lumen. The tube was cut just below the foreign body and it was found to be completely occluded by a rubber tip which is used over the adapter of the Abbott Venopak.