

terior wall damage was made, and the operation was cancelled. Follow-up studies showed persistence of the ECG changes and an increase in the serum glutamic oxalacetic transaminase level. A definitive diagnosis of anterior wall myocardial infarction was established, and the patient treated on the medical ward for five weeks. He was discharged with instructions to adhere strictly to his ulcer regimen.

COMMENT

Acute myocardial infarction manifesting itself solely by bradycardia is unusual. In most patients with acute myocardial infarction, the heart rate is accelerated.^{1,2} Slowing of the heart due to either vagal inhibition or atrioventricular block has been noted in patients who are in shock.²

Prior to hospitalization, this 50 year old man had been able to perform physically strenuous work without any disturbing cardiovascular signs or symptoms. The findings of the preoperative routine electrocardiogram were not pathognomonic, although suggestive of arteriosclerotic heart disease. Left axis deviation may be an expression of left ventricular hypertrophy, but may also represent a horizontal heart position. Right bundle branch block is seen in patients without organic heart disease.³ In Reusch and Vivas' series of 100 patients with complete right bundle branch block by electrocardiographic diagnosis, only 68 had associated heart disease, the most common disorder in these being arteriosclerosis.⁴

Repeated clinical experiences have suggested that emotional excitement or unusual physical exertion may precipitate the development of myocardial infarction. Underlying coronary artery disease was present in all such instances.⁵ One may postulate that apprehension and fear of the operation acted as the predisposing factor in this patient.

An electrocardiogram taken shortly after a myocardial infarction may not show diagnostic changes.⁵ It is frequently necessary to take serial electrocardiograms to demonstrate progressive changes in order to substantiate the diagnosis.⁵ A previous tracing can be of great value for comparison.

In summary, this case report is illustrative of (1) the value of a routine preoperative electrocardiogram in a healthy 50 year old man, and (2) the possible implications of an unexplained bradycardia.

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An Unusual Case of Respiratory Obstruction

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During a period spent with our Aid to Developing Countries Mission we were recently confronted with a strange hazard to anesthesia.

The patient, a 28 year old African woman suffering from an abscess of the abdominal wall, was admitted to theater for incision and drainage. Premedication (0.5 mg. atropine) was injected intravenously and immediately followed by 250 mg. thiopental 2.5 per cent.

On losing consciousness the patient became completely obstructed despite attempts to turn the head to the side and to pull the jaw forward. An oropharyngeal airway was inserted but was held up in the mouth to the accompaniment of clicking noises. Laryngoscopy was performed which showed the oropharynx to be full of glass beads and marbles which were laboriously fished out with the help of a

Magill forceps. After the pharynx was cleared of foreign bodies, the lungs were inflated with oxygen and the anesthetic continued. The patient awoke at the end of the operation and loudly bewailed the loss of her most treasured possessions (as was translated to us by the theater staff). The beads were returned to the patient who promptly replaced them in her mouth.

We should like to point out that prior to operation no attempt was made to engage the

patient in conversation, there being no common language. Further, as dentures are virtually unknown to the African population, the mouth was not inspected for foreign bodies. This proved to be a serious oversight of a routine precaution. Retaining valuables in the mouth is quite common among the Africans. It is hoped that this case report may prevent further incidents of this sort by alerting physicians going to African countries for the first time.

Halothane Anesthesia and Catecholamine Levels in a Patient with Pheochromocytoma

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The surgical excision of pheochromocytoma is a challenging problem for the anesthetist. Periods of acute hypertension due to increased liberation of the catecholamines can occur during induction of anesthesia, intubation of the trachea and surgical manipulation of the tumor. Various drugs, such as phentolamine (Regitine), piperoxan (Benodaine), or trimetaphan (Arfonad) have been used during anesthesia and operation to prevent these abrupt elevations of arterial blood pressure.¹

Recent findings in our laboratory indicate that halothane suppresses the sympatho-adrenal activity causing a depletion of epinephrine with no increase of norepinephrine in the cardiovascular tissues.² The rationale for the administration of halothane anesthesia for excision of adrenal pheochromocytoma is based on these findings. The following case report illustrates the advantages of halothane anesthesia in maintaining blood pressure within physiologic levels by suppression of circulating

catecholamine concentrations during operation in a patient with pheochromocytoma.

CASE REPORT

A 59 year old white married woman was admitted with a five-year history of fatigue, profuse sweating, itching and flushing. Her symptoms had become more severe and episodes of throbbing headache had developed approximately one year before admission.

Physical examination revealed a well-developed, slightly hyperpigmented woman, weighing 110 pounds without any acute distress. Blood pressure was 160/110 mm. of mercury in the supine position and 140/80 mm. of mercury in the upright position. Routine laboratory tests were normal. Urinary catecholamine excretion was 1075 $\mu\text{g.}$ per day (normal: 100 $\mu\text{g.}$ per day), and 3-methoxy, 4-hydroxymandelic acid (VMA) was 27.2 mg. per day (normal: 5 mg. per day). The day prior to operation, plasma catecholamine levels were still elevated (10 $\mu\text{g./liter}$ for norepinephrine and 1.2 $\mu\text{g./liter}$ for epinephrine). Electrocardiogram showed left ventricular hypertrophy and strain. The intravenous administration of phentolamine (5 mg.) resulted in a drop of arterial blood pressure from 160/70 to 80/60 mm. of mercury. The diagnosis of pheochromocytoma was made and the patient was scheduled for an exploratory laparotomy. The patient was given 500 ml. of plasma the day before operation.

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