SCOTTISH SOCIETY OF ANÆSTHETISTS.

At the meeting of the Scottish Society of Anæsthetists, held in Glasgow on May 26th, Dr. J. S. Ross communicated two unusual cases of intratracheal anaesthesia. The first was a young man with a rapidly increasing goitre causing marked obstruction of respiration. He was anaesthetised by a mixture, and, as expected, the air-way became completely obstructed at the end of the induction. An intratracheal catheter was introduced by the direct method. It was then found that while air could be freely introduced along the catheter into the chest, the walls of the trachea enclosed the catheter so closely that no reverse current of air could take place. The warning note was given by the increase of pressure in the intratracheal instrument itself causing escape from the safety-valve, examination showing that no air was escaping through the mouth. The anaesthesia was conducted by alternately connecting and disconnecting the apparatus with the catheter. Enucleation of the goitre was effected very rapidly, after which all difficulty disappeared and the man made an excellent recovery.

The second case was one of retro-sternal goitre. In the light of the experience of the previous case it was regarded as possible that a similar difficulty might be experienced in this case, but in actual practice the induction of anaesthesia, the introduction of the tube and the earlier stages of the intratracheal anaesthesia proceeded smoothly. At a later stage of the operation, however, an obstruction of the outflow did actually occur. The operation was one of very considerable difficulty and while the patient left the table alive, death took place some few hours later, apparently from shock. It was also noted that there was a considerable amount of haemorrhage during the operation.

Dr. Fairlie stated that he had met with two cases, one of epithelioma of the tongue and the other glands in the neck, anaesthetised by the intratracheal method, where the return flow of air had been obstructed. Both patients were of the short-necked type and obstruction was removed simply by keeping forward the jaw. There was no spasm of the glottis.

Dr. Thomson said he had never met any case of obstruction so long as the tube was in position, but to his knowledge two cases had died after the return to bed some considerable time after the tube had been removed.
Dr. J. H. Gibbs mentioned a case which he would have to anaesthetise within the next few days: a very stout lady who had suffered for many years from asthma and who now had a markedly dilated heart with signs of blood pressure. The removal of a septic tooth was absolutely essential to give the patient comfort and a local anaesthetic would, in his judgment, be impossible. He proposed to deal with the case by open ethyl-chloride with oxygen run into the corner of the mouth, and this procedure appeared to be regarded by most members as very suitable.

AMERICAN AND PACIFIC COAST ANÆSTHETISTS.

A Joint Meeting of the American and Pacific Coast Anæsthetists, with the Section on Anaesthesiology of the California State Medical Society, was held at San Francisco, June 22—26.

Among the items on the programme were the following:

The Effects of Posture on Relaxation Under Anæsthesia. Caroline B. Palmer.
Reversing Anaesthetic By-Effects through Selective Medication. Lorulli A. Rethwilm.
Spinal Anæsthesia in Obstetrics and Cæsarean Section. H. T. Cooke.
Selective Anæsthesia for Plastic Surgery of the Mouth and Jaw. Frank Chandler.
Keeping Anaesthetic Records and What They Show. John S. Lundy.
Medico-Legal and Obstetrical Considerations of Scopolamine Anaæsthesia. R. E. House.
Ethylene-Oxygen Anaesthesia: Research and Clinical Considerations. A. B. Luckhardt and Isabella C. Herb.
Pre- and Post-Operative Care of Patients from the Anaesthetist’s View-point. R. F. Hastreiter.