Info Request on Possible Awareness Case

The article written by Karen B. Domino, M.D., in the March 2007 issue regarding a "Registry on Awareness under Anesthesia" brought to mind an incident I encountered a few years ago when serving as chair of a survey team credentialing a surgery center for AAAHC.

An anesthesiologist at that center was attempting to maximize the rate of return to postoperative consciousness in the recovery room and subsequent early discharge from the facility. The technique used was to administer extremely small doses of propofol and miniscule doses of short-acting narcotic, and simultaneously run a continuous esmolol beta-blocker infusion to blunt the patient's cardiovascular response (tachycardia and hypertension).

As a surveyor reviewing charts from months prior, I was unable to interview the patient regarding awareness during anesthesia. It seems to me that such a technique would increase the likelihood of awareness, and I am wondering if there is any information pro or con regarding this technique? Does Dr. Domino have any information on this subject?

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Korean War Vet Not So Well-Equipped

I read with great interest and much humor the articles in the March 2007 *NEWSLETTER* on combat trauma. The pictures of the anesthesia setup floored me! What equipment!

I was the anesthesiologist at Baker Medical Company, 1st Marine Division in the Korean War, operating within one mile off the Main Line of Resistance (MLR) in the last several months of the war, just south of the Imgin River, 20 miles north of Seoul, when the North Koreans were trying desperately to win back territory.

My anesthesia setup consisted of two portable Heidbrink anesthesia machines in "suitcases" about 15 x 15 x 24 inches, with a CO_2 absorber, a G cylinder of oxygen and a G cylinder of nitrous oxide, plus several intravenous drugs. Two operating tables were set up end to end, with one stool for me in between so that I could handle two cases at the same time. Thanks to terrific cooks, I ate all my meals in the O.R. while operations were going on, and I left the O.R. only to go to the head, while a dentist covered for me. Every doctor carried sidearms, i.e., .45 caliber automatics, because of the nearness to the MLR and because an English medical company had been overrun recently. All corpsmen stacked their carbines along the O.R. wall for instant possible use. The sterilizer was a Coleman-type, gas-pumped heat source, with water obtained from a brook which ran outside the medical setup. Thumbs became sore from pumping the air compressor. The Army "supplied" our drugs, and they were very meager, making our corpsmen the greatest thieves in the world, getting the necessary drugs by stealing them from the Army depot in Inchon, 25 miles away.

We were so close to the line and the chopper pilots were so good, carrying two patients at a time on the sled-like platforms on the sides of the small choppers, we received our wounded Marines before they had time to bleed much and certainly were never in shock. We heard no big guns but heard plenty of swishes of big stuff going above us.

In two battles, Berlin and East Berlin, in the mountains just below the Imjin River: In the first battle, I got 14 hours sleep; and in the second battle, I got five hours sleep. That's five hours in five days! Every one of my patients went home! In so-called "minor" surgery, the wounded were numerous, and all wounds were handled with plenty of local anesthesia with stretchers on boxes.

Two of the surgeons reported the largest series of arterial grafts in the world at that time from the 1st Marine Division. With all the fancy equipment the physicians use in Iraq, I wonder if their record was as good as ours.

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